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Royal Commission on
New Reproductive Technologies



Commission royale sur les
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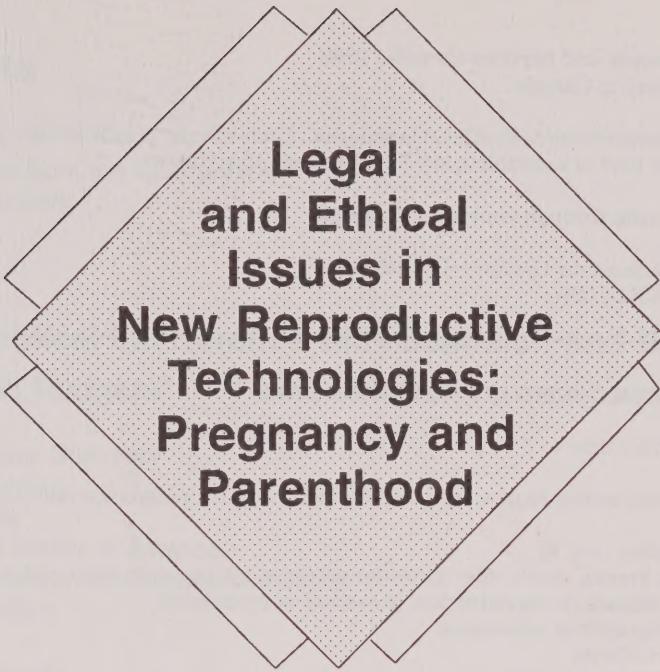
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LEGAL AND ETHICAL ISSUES IN NEW REPRODUCTIVE TECHNOLOGIES: **Pregnancy and Parenthood**

Research Studies of the
Royal Commission on
New Reproductive Technologies





**Legal
and Ethical
Issues in
New Reproductive
Technologies:
Pregnancy and
Parenthood**

**Volume 4 of the
Research Studies**

Royal Commission on
New Reproductive Technologies

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Consistent with the Commission's commitment to full equality between men and women, care has been taken throughout this volume to use gender-neutral language wherever possible.

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Preface from the Chairperson



As Canadians living in the last decade of the twentieth century, we face unprecedented choices about procreation. Our responses to those choices — as individuals and as a society — say much about what we value and what our priorities are. Some technologies, such as those for assisted reproduction, are unlikely to become a common means of having a family — although the number of children born as a result of these techniques is greater than the number of infants placed for adoption in Canada. Others, such as ultrasound during pregnancy, are already generally accepted, and half of all pregnant women aged 35 and over undergo prenatal diagnostic procedures. Still other technologies, such as fetal tissue research, have little to do with reproduction as such, but may be of benefit to people suffering from diseases such as Parkinson's; they raise important ethical issues in the use and handling of reproductive tissues.

It is clear that opportunities for technological intervention raise issues that affect all of society; in addition, access to the technologies depends on the existence of public structures and policies to provide them. The values and priorities of society, as expressed through its institutions, laws, and funding arrangements, will affect individual options and choices.

As Canadians became more aware of these technologies throughout the 1980s, there was a growing awareness that there was an unacceptably large gap between the rapid pace of technological change and the policy development needed to guide decisions about whether and how to use such powerful technologies. There was also a realization of how little reliable information was available to make the needed policy decisions. In addition, many of the attitudes and assumptions underlying the way in which technologies were being developed and made available did not reflect the profound changes that have been transforming Canada in recent decades. Individual cases were being dealt with in isolation, and often in the absence of informed social consensus. At the same time, Canadians were looking

more critically at the role of science and technology in their lives in general, becoming more aware of their limited capacity to solve society's problems.

These concerns came together in the creation of the Royal Commission on New Reproductive Technologies. The Commission was established by the federal government in October 1989, with a wide-ranging and complex mandate. It is important to understand that the Commission was asked to consider the technologies' impact not only on society, but also on specific groups in society, particularly women and children. It was asked to consider not only the technologies' scientific and medical aspects, but also their ethical, legal, social, economic, and health implications. Its mandate was extensive, as it was directed to examine not only current developments in the area of new reproductive technologies, but also potential ones; not only techniques related to assisted conception, but also those of prenatal diagnosis; not only the condition of infertility, but also its causes and prevention; not only applications of technology, but also research, particularly embryo and fetal tissue research.

The appointment of a Royal Commission provided an opportunity to collect much-needed information, to foster public awareness and public debate, and to provide a principled framework for Canadian public policy on the use or restriction of these technologies.

The Commission set three broad goals for its work: to provide direction for public policy by making sound, practical, and principled recommendations; to leave a legacy of increased knowledge to benefit Canadian and international experience with new reproductive technologies; and to enhance public awareness and understanding of the issues surrounding new reproductive technologies to facilitate public participation in determining the future of the technologies and their place in Canadian society.

To fulfil these goals, the Commission held extensive public consultations, including private sessions for people with personal experiences of the technologies that they did not want to discuss in a public forum, and it developed an interdisciplinary research program to ensure that its recommendations would be informed by rigorous and wide-ranging research. In fact, the Commission published some of that research in advance of the Final Report to assist those working in the field of reproductive health and new reproductive technologies and to help inform the public.

The results of the research program are presented in these volumes. In all, the Commission developed and gathered an enormous body of information and analysis on which to base its recommendations, much of it available in Canada for the first time. This solid base of research findings helped to clarify the issues and produce practical and useful recommendations based on reliable data about the reality of the situation, not on speculation.

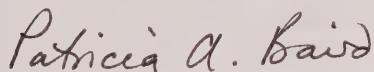
The Commission sought the involvement of the most qualified researchers to help develop its research projects. In total, more than 300

scholars and academics representing more than 70 disciplines — including the social sciences, humanities, medicine, genetics, life sciences, law, ethics, philosophy, and theology — at some 21 Canadian universities and 13 hospitals, clinics, and other institutions were involved in the research program.

The Commission was committed to a research process with high standards and a protocol that included internal and external peer review for content and methodology, first at the design stage and later at the report stage. Authors were asked to respond to these reviews, and the process resulted in the achievement of a high standard of work. The protocol was completed before the publication of the studies in this series of research volumes. Researchers using human subjects were required to comply with appropriate ethical review standards.

These volumes of research studies reflect the Commission's wide mandate. We believe the findings and analysis contained in these volumes will be useful for many people, both in this country and elsewhere.

Along with the other Commissioners, I would like to take this opportunity to extend my appreciation and thanks to the researchers and external reviewers who have given tremendous amounts of time and thought to the Commission. I would also like to acknowledge the entire Commission staff for their hard work, dedication, and commitment over the life of the Commission. Finally, I would like to thank the more than 40 000 Canadians who were involved in the many facets of the Commission's work. Their contribution has been invaluable.

A handwritten signature in black ink that reads "Patricia A. Baird". The signature is fluid and cursive, with "Patricia" on the top line and "A. Baird" on the bottom line.

Patricia Baird, M.D., C.M., FRCPC, F.C.C.M.G.

Introduction



The four studies that comprise this volume are, ostensibly, about legal issues arising from the existence and use of new reproductive technologies. At their base, however, they are about something much more fundamental — how we define the rights and responsibilities attached to the concepts of motherhood, fatherhood, and families, and what role we see the state as having in their regulation.

Thus, Sanda Rodgers examines how the state may seek to protect the fetus by interfering in the specific pregnancy of one woman, while Judy Fudge and Eric Tucker explore other means by which the state seeks to protect the health of fetuses in general by regulating the behaviour of all pregnant women, and sometimes all women of reproductive age. Elizabeth Sloss and Roxanne Mykittuk outline how new reproductive technologies have affected how we define maternity, paternity, and families, and look at how family law can respond to these changed definitions. And Juliette Guichon subjects preconception, or surrogacy, arrangements to in-depth scrutiny, examining, along the way, problems in how the labels of mother, father, and family are applied in these situations.

Taken together, these studies confirm the enormous range of legal issues associated with new reproductive technologies. Many of the topics they explore repeat themes that were first raised in Volume 3. For instance, Juliette Guichon provides a critical analysis of the use of the contract model when applied to human relationships, an extension of the focus in Volume 3 on contract law as it applies to the control and use of the materials, products, and processes arising out of the development and use of new reproductive technologies.

The studies in this volume draw heavily on international, Canadian, and provincial law. In this respect, the breadth of scholarship of these studies constitute an important contribution to our collective understanding of the legal implications of new reproductive technologies.

The Studies

In her examination of juridical interference with pregnancy and birth, Sandra Rodgers analyzes constitutional law, the *Canadian Charter of Rights and Freedoms*, criminal law, and provincial legislation which provides for differential treatment of women. She outlines how interfering in a pregnancy in the supposed interests of the fetus raises tough questions that go to the heart of the principles embodied in the Charter, and challenge how we, as a society, view reproduction and the relationship between a woman and the fetus she is carrying. At the core of the debate over juridical interference is a profound disagreement about the status of the pregnant woman, the status of the fetus, and the nature of the relationship between the woman and the fetus.

Society's view of this relationship has changed in recent years as a result of several related developments. Our ability to use ultrasound to gain more information about the fetus at an earlier stage of development, to save babies born at earlier stages of development, and to correct some anomalies *in utero* through fetal surgery have all led some physicians to view the fetus as a patient separate from its mother, and society to believe that medical science is capable of intervening in pregnancy solely for the sake of the fetus. These developments, while all of value in and of themselves, contribute to a sense that juridical interference in gestation and birth is feasible, effective, and desirable.

That it is feasible is unquestioned. While the level of interference is significantly lower in Canada than in the United States, as Professor Rodgers describes, the issues raised in both jurisdictions are identical, and the question is posed whether we, as a nation, want to follow the American model, with its preponderant emphasis on sanctions, or take steps to create a uniquely Canadian approach to protecting fetal health.

One reason for opting for the latter option is that juridical intervention is, as Professor Rodgers documents, not effective. It may, in fact, be counterproductive, discouraging women at risk from seeking medical assistance, and encouraging them to fear, distrust, and, perhaps, lie to health care providers in order to avoid legal penalties. In terms of health outcomes, the aberrant behaviour that attracts state suspicion is, most likely, much less threatening to fetal and neonatal health than the well-documented negative impact of poverty. The imbalance that Professor Rodgers documents between state attempts to sanction or punish individual pregnant women and state support for all pregnant women that seeks to alleviate the impact of poverty is striking and unsettling.

On the third question, whether juridical interference is desirable, Professor Rodgers responds with a rousing "no." Not only on the grounds of its ineffectiveness, but also on the grounds that it is discriminatory against all women, and some women in particular. Professor Rodgers' analysis of actual cases leads her to conclude that the women most vulnerable to state interference with gestation and birth are those who are

also vulnerable because of their race or their economic situation. Poor women, women of colour, Aboriginal women, and women already dependent on social services experience a disproportionately high level of such interference.

Juridical intervention in gestation and birth is most commonly understood as the legal system overriding a pregnant woman's autonomy in the interests of her fetus, who is considered to be at risk by virtue of the mother's behaviour. Juridical interference, however, also encompasses workplace policies aimed at protecting the reproductive health of workers. Professor Rodgers notes that, while current provisions tend to be discriminatory, in that they limit access by women of reproductive age to some jobs, if they are simply dropped, without further changes, workers will be left unprotected.

Judy Fudge and Eric Tucker examine this aspect of juridical intervention more closely, in their paper on reproductive hazards in the workplace. They situate reproductive health protection within the context of the generally unimpressive history of the protection of the health of workers, and note that any efforts to improve the system of laws and programs protecting worker health in general would probably have a positive impact on the protection of reproductive health.

The little that has been done to protect reproductive health, the authors note, has not always had positive effects. The choice to emphasize fetal health over the reproductive health of all workers has been used to deny all women of childbearing age access to certain jobs, many of them jobs that are not traditionally held by women. At the same time, it has left the reproductive health of men unprotected, despite the growing evidence of the important role of men in fetal health. This approach also fosters the view that it is better to remove the worker from the hazard than the hazard from the workplace, an approach the authors reject; instead, they make several policy recommendations which emphasize equity, prevention, compliance and enforcement, and compensation. In particular, they note the need for protection of breast-feeding as well as pregnant women; the need to make workplaces safe for workers even before conception; the need for incentives for employers and manufacturers to provide safe working environments; and the need to provide support and compensation for parents attending to the special needs of a child damaged as a result of parental exposure to a workplace hazard.

Ultimately, both Professor Rodgers and Drs. Fudge and Tucker question whether it is fair to subject women, on the basis of their reproductive capacities, to different laws and rules than are imposed to men. Their answer, in both papers, is no.

Elizabeth Sloss and Roxanne Mykitiuk paint a picture of family law that is very similar to the portrait of reproductive hazards in the workplace painted by Drs. Fudge and Tucker — a patchwork of measures that are not equal to the legal challenges being posed by new reproductive technologies. They contend that assisted human reproduction complicates the legal

significance of parenthood by making it possible for more than two people to be involved in the procreative process. This fact, together with the increasingly complex nature of family structures today, are posing challenges for family law.

In the context of these challenges, Ms. Sloss and Ms. Mykitiuk suggest two paths for future action. The first is to leave the current patchwork situation as it stands. This would not encourage any uniformity of legal responses to new reproductive technologies across Canada as a whole, and would leave specific situations to be worked out between private individuals, usually through contract law approaches. This might, however, permit situations, such as preconception arrangements, that are not acceptable to society as a whole.

The other approach, the one the authors support, is regulation. They recommend both moderate legislative intervention, where legislatures would identify those aspects of family law most in need of updating or modifying to respond to the particular situations created by the use of new reproductive technologies, and full regulation, a much stronger and more comprehensive legislative and regulatory approach that would be used only in very difficult situations, such as preconception arrangements.

Preconception arrangements do, in fact, merit separate attention, both because of their complexity, and because of the ethical principles involved. Juliette Guichon's thoughtful consideration of both the legal and the ethical aspects of these arrangements is based on an extensive analysis of the experience with and jurisprudence on this practice in Canada, the United Kingdom, the United States, and Australia. She makes the important point that the general public, and, indeed, policy makers as well, are operating under an incomplete and misleading view of preconception arrangements in which a fertile woman happily and altruistically makes a "gift" of a baby to a couple that cannot conceive. The reality Ms. Guichon describes is a situation involving highly inequitable relationships between affluent couples aided by aggressive brokers, on the one hand, and women of lower education levels and income on the other hand, often pressured into becoming gestating mothers by the commissioning couple, and, sometimes, by her own husband and family. Ms. Guichon also makes it clear that preconception arrangements are going ahead without any understanding of the long-term effects of the practice on all the parties involved, but particularly on the gestating mother.

The other point that comes across in this paper is the fact that preconception arrangements inevitably result in a child being treated as a commodity, with implications for how society values children, pregnancy, and childbirth, as well as for the role of women in reproduction. It is the relationships between individuals that are central to preconception arrangements that prompt Ms. Guichon to propose that family law is a more appropriate legal approach than contract law to the special issues posed by preconception arrangements.

Finally, Jennifer Kitts provides an overview of the literature in the area of surrogate parenting. This bibliography was compiled early in the Commission's mandate. While not exhaustive, it comprises a listing of books, articles, and theses examining different aspects of surrogate parenting as of 1990, and it will be of value to both the scholar seeking in-depth information and the layperson wanting more information on the issues raised in this volume.

Conclusion

In many ways, the studies in this volume deal with situations that are ethically unacceptable to Canadian society. This is especially the case with juridical intervention into gestation and birth and preconception arrangements, where the issues are unacceptable within the context of the ethical framework adopted by the Commission and inconsistent with generally held Canadian values, as expressed in the Charter.

The Commission, in its Final Report, has recommended clearly against these two practices. Commissioners view the recourse to any form of state intervention in gestation and birth as evidence that the ethic of care has broken down, and that the sense of connectedness and mutual support which surround pregnancy and birth has been ruptured, to be replaced by an adversarial situation in which the rights of the fetus are pitted against the rights of the pregnant woman. In this respect, Sanda Rodgers' study is an important base upon which to base any future legislative initiatives or judicial decisions with regard to state intervention in gestation or birth. Similarly, Juliette Guichon outlines a set of practices that clearly undermine the status of women and the nature of the family, and that are contrary to the Commission's guiding principles of equality, respect for life, protection of the vulnerable, and non-commercialization of reproduction.

The same conclusion, however, is no less true, if less dramatic, with workplace regulation of reproductive hazards and with family law. It is unacceptable in our society that women should be subject to discriminatory treatment in the workplace in order to "protect" their fetuses from reproductive hazards, and equally unacceptable that the only available alternative today is no protection at all. It is equally unacceptable that families created through the use of new reproductive technologies should be vulnerable because existing family law is inadequate to their situations.

What becomes clear in all of these situations is that the legal implications of new reproductive technologies have to be clarified not only within the confines of the law as a system of rules, but within a broad, ethical context that ensures that the interests of all affected individuals are considered. The state has a positive role to play in ensuring that these interests are protected; it does not have a role in infringing on the rights of individuals.



Juridical Interference with Gestation and Birth

Sanda Rodgers



Executive Summary

Constitutional law, the *Canadian Charter of Rights and Freedoms*, criminal law, and provincial legislation that provides for differential treatment of women are included in the scope of this report.

The level of interference with gestation and birth that occurs in the United States is significantly greater than that which occurs in Canada. However, although on a smaller scale, the issues raised in Canada are exactly those raised in the United States. Workplace policies, addiction issues, sentencing parameters, and third party health care decisions are all relevant to Canadian cases. Actual and proposed legislative interference with gestation and birth has occurred here as well. Professional health care organizations, legislatures, and law reform bodies have considered proposals for and against interference with reproduction and gestation.

In both Canada and the United States, those women who are subject to interference with gestation and birth are also those who are subject to state scrutiny because of their economic vulnerability and previous engagement with state services. In the United States and in Canada, there is evidence of racism and cultural insensitivity with respect to the health care needs of many women.

To date, in the limited number of cases considering the constitutionality of legislative preference for the fetus, no court in Canada or in the United States has upheld any such statutory preference. Policies that prefer the fetus, such as workplace exclusion

polices, have been held to violate anti-discrimination provisions and human rights codes. Where litigation is based on common law, the conclusion at the appeal level has been the same. Preference to the fetus has not been maintained.

An additional concern is the degree to which the cases examined show women living in relationships subject to male violence. These cases have revealed a tendency to ignore the male role while imposing health care on the woman or denying her custody of her child.

In short, juridical intervention in gestation and birth reflects the patriarchal nature of North American society. Legislative and judicial responses to social problems have proven to be counterproductive. Therefore, the author suggests, the appropriate response to pregnancy and childbirth is to offer easy access to culturally appropriate support services for women and children, designed by women to meet the broad needs of women and children.

Introduction

The mandate of the Royal Commission on New Reproductive Technologies specifically directs the Commission to consider the nature and scope of "judicial interventions during gestation and birth."

Prior to the appointment of the Commission, a series of cases in various provinces had attracted the attention of legal and social commentators.¹ These cases concerned various instances of judicial (that is, court-based) intervention into the conduct and pattern of behaviour of individual pregnant women. Several cases concerned the imposition of medical care, including a Caesarian section, on the woman, despite her refusal of the suggested treatment. One involved the use of provincial mental health legislation to detain a pregnant woman perceived to be a threat to the fetus she carried. Others involved judicial suggestion that conduct by the pregnant woman had constituted "prenatal" abuse of the fetus, in the context of child welfare proceedings commenced after the birth of the child. In one case, a sentence of incarceration was imposed on a woman because she was pregnant, where such a sentence would not ordinarily have been imposed for the offence committed.

These Canadian cases, while relatively few in number, occurred in a North American context of similar cases and initiatives, often reported in the Canadian press, arising in the United States. They occurred in the Canadian context of a series of abortion-related actions brought on behalf of husbands, partners, and putative fathers that raised similar concerns about the use of the court-based judicial system to control women's behaviour. They occurred in a climate of increasing concern about the use of addictive drugs in Canada, including the impact of alcohol on fetal development, and in a context of some, although little and little-noted, legislative activity around such use. They occurred at a time when the

issue of the impact of pregnancy or reproductive capacity on workplace entitlement was unresolved.

These cases raised concerns about the appropriate state response to the situation of the pregnant woman in any situation that appeared to be injurious to the fetus she was carrying. They raised concerns about the refusal or inability of women to act in ways that were judged by others to be in the interest of a healthy outcome to the pregnancy. They raised concerns about the failure of women to follow the advice of members of the helping professions. They raised serious questions about interference with women's reproductive autonomy and concerns about discrimination and equality, given the lack of judicial and legislative interference with male reproductive autonomy. They raised questions about the potential harm that might be caused to a fetus by male behaviour, work environments, and aspects of the mother's lifestyle, and about the use of sanctions to reduce that potential.

This study is a response to some of those questions and to the specific requirement of the mandate that the Commission consider "judicial interventions during gestation and birth." The reference to that issue specifically in the mandate of the Commission indicates a level of government and public concern about the appropriate response to the questions that these instances of judicial intervention pose.

The study will also document the nature and scope of the various forms of juridical intervention into pregnancy and childbirth. The concept of juridical intervention will be drawn sufficiently widely to encompass case law, legislative initiatives, and judicial practices. Different workplace policies at the provincial and federal level will be catalogued and reviewed. The study will also examine the judicial response to the practices of non-judicial entities, particularly to employers' workplace policies specifically applicable to pregnant women or women of reproductive capacity, since such policies fall within the description "judicial interventions during gestation and birth."

The study will not include judicial intervention into pregnancy and childbirth raised in the context of contract motherhood (surrogacy), nor will it deal specifically with judicial or legislative intervention into access to therapeutic abortion procedures. The issues raised by contract motherhood are the subject of other research proposals submitted to the Commission. The issues of abortion regulation are beyond the scope of this study, except insofar as legislative or judicial statements concerning abortion are persuasive with regard to the issues raised more directly by this study.

It is the objective of this study to describe the terrain of legal intervention into pregnancy and childbirth. The study will paint a picture of the scope of this intervention in Canada at both the federal and provincial levels. Attention will be paid to legislative and regulatory intervention, as well as to judicial intervention into the childbearing experiences of Canadian women. The legality and constitutionality of such intervention will be delineated.

4 Legal and Ethical Issues in NRTs

A similar picture of American legislative and judicial initiatives will be provided. There is a significant level of American activity, which often finds reflection in decisions of the Canadian judiciary and in initiatives of the federal and provincial legislatures. As well, critical appraisal of the American initiatives is further advanced. Differences in social structures, particularly in the delivery of health care services, will be noted and assessed.

International obligations, including United Nations initiatives and International Labour Organization obligations, will be briefly described in an appendix, and a sketch will be drawn of various initiatives in Europe.

In the treatment of these various topics, attention will be paid to women who have been subjected to legislative and judicial interference into their pregnancies and their birthing experiences. The economic class from which women who attract the state's attention come will be noted, as will issues of race and racism that interventions of this sort may imply.

The objective of this study is to identify appropriate forms of state support for the health of pregnant women and the fetuses that they carry. To this end, this study will critically assess the appropriate form, if any, for juridical intervention into pregnancy and childbirth, will consider alternative approaches to achieve the agreed objectives of maternal and fetal health, and will suggest recommendations that the Commission might make with regard to that part of its mandate.

In carrying out this critical assessment, the author has been careful to be accurate in all descriptions of legal and other materials. There has been no distortion or exaggeration of the materials. Rather, I have rendered, with the objectivity available to those undertaking legal interpretation, the content and reasoning of those materials. It is anticipated that this careful attention to soundness and objectivity will make the conclusions of this report persuasive.

Canada

Constitutional Law and Reproduction²

Canadian legal discourse traditionally begins with an analysis of the jurisdictional powers and responsibilities of the various levels of government in order to assess which level has the authority to undertake the initiatives in question. Modern constitutional analysis then requires a consideration of the scope for legislative action in the context and constitutional confines of the *Canadian Charter of Rights and Freedoms*. Any assessment of potentially discriminatory measures, which interfere with gestation and birth clearly is, must also account for the impact of the various provincial human rights codes. Actions that interfere with reproductive autonomy on behalf of the fetus must be measured against both the Charter and the provincial codes.

The jurisdictional issues concerning the provision of health services will be canvassed only briefly, simply for the purpose of setting the stage within which the dialogue around the provision of services occurs.

Sections 91 and 92 of the Constitution Act, 1867

Juridical interference with gestation and birth, as defined for this study, extends to several heads of constitutional authority. The greatest number of areas fall to the jurisdiction of the provinces rather than of the federal government.³

The one major exception lies in the domain of criminal law, which is under federal jurisdiction. Thus, any attempt to criminalize behaviour deemed to harm the fetus falls within federal jurisdiction under section 91. Sentencing for federal criminal code offences also lies within federal jurisdiction. In addition, jurisdiction over undertakings characterized as federal would likewise fall within federal jurisdiction. Thus, employment exclusion policies specific to federal undertakings would be governed by federal jurisdiction.

Jurisdiction over health care, including addiction treatment,⁴ child welfare legislation, mental health legislation, and labour and workplace legislation applicable to undertakings not specifically federal all fall within the constitutional jurisdiction of the provinces. In particular, these areas of regulation are reserved to the provinces under "hospitals," section 92(7); "civil rights" within the meaning of section 92(13); and "matters of a merely local or private nature in the province," section 92(16).

Charter Challenges and Challenges Under the Human Rights Codes

Traditionally, the first line of attack on legislative policies was to allege that the level of government responsible for the policies lacked jurisdictional authority to pass the provisions being challenged. More recently, legislative initiatives alleged to be inappropriate by one or another party are more likely to be challenged, or are additionally challenged, either as contravening provincial human rights codes or as failing to comply with the rights entrenched in the *Canadian Charter of Rights and Freedoms*. The extent of the possibility of challenge is different in both cases.

Legal challenge to a policy for violating the *Canadian Charter of Rights and Freedoms* is available to attack federal or provincial legislation or regulation. Charter challenge is also available for policies of institutions that have a sufficient connection to state authority to be characterized as initiatives on behalf of the state. Charter challenge is not available to review the behaviour or policies of individuals with no connection to the state. Areas that fall exclusively within the common law (law made in judges' decisions of cases) or the civil law are assessed for Charter compliance, if the Charter is generally applicable to the subject of litigation. A similar interpretation has been provided for the meaning of "prescribed by law" within the text of section 1 of the Charter.⁵

Provincial anti-discrimination provisions, contained in the provincial human rights codes, apply to all activity that occurs in the province whether under the control of private individuals or through the auspices of legislation or a provincial organization. In some cases, the language of the human rights codes is more specific than that of the *Canadian Charter of Rights and Freedoms*. Nor are there equivalents in the provincial human rights codes of the various excuses of the Charter, specifically the section 1 defence and the exculpatory language of section 7 concerning the "principles of fundamental justice."

The Canadian Charter of Rights and Freedoms

This section will discuss those Charter rights most relevant to constitutional assessment of the kinds of juridical intervention into gestation and birth that this paper is concerned with. Potential forms of interference would include limits imposed on women simply because of pregnancy or capacity for pregnancy, such as feticide offences, the criminalization of pregnant women's behaviour, workplace exclusion of pregnant women or women of childbearing capacity, forced treatment, detention of pregnant women, and the implementation of legal concepts of prenatal abuse.

This brief sketch will outline the existing parameters of Charter interpretation as formulated in cases that, primarily, are analogous but not identical to the situations with which we are concerned.⁶ Discussion of the constitutionality of specific current federal and provincial initiatives for constitutional validity will occur later in the text.

Section 7: "Everyone has the right to life, liberty and security of the person" — the meaning of "everyone" and of "person"

To date, the clear direction of Canadian courts in interpreting the terms identifying those to whom rights attach has been to conclude that such terms do not include the fetus at any point in gestation.⁷ Therefore, where legislation refers to a "person," the fetus is not included.⁸ A similar legal conclusion has been reached with regard to the statutory use of the term "child"⁹ and of the term "human being."¹⁰ The Supreme Court of Canada was of this view in *Tremblay v. Daigle*, although the Court did not specifically comment on the use of the terms "everyone" and "person" in the *Canadian Charter of Rights and Freedoms*, as the question was not squarely before the Court. One may predict with confidence, however, that the Court's interpretation of the various terms in that case would exclude the fetus from the term "everyone" and "person" in section 7. The result is that no one is entitled to section 7 Charter protection unless first born alive from the body of a mother.

The Court is of the view that legislatures that intend legislation to be extended to the fetus are capable of clearly so stating. General language will not be construed to include the fetus. The fetus must be specifically referred to. Such an inclusion would not necessarily withstand constitutional scrutiny. That determination cannot be made in the

abstract; it requires full review of the legislative provisions with reference to any other persons affected by such a provision.

"Life, Liberty and Security"

In *R. v. Morgentaler*,¹¹ the Supreme Court of Canada commented at length on the meaning and scope of "life, liberty and security."¹² The judgment struck down section 251 of the Criminal Code of Canada, limiting non-criminal abortions to those that occurred within a hospital and with the permission of a therapeutic abortion committee.

The *Morgentaler* case concerned, among other legal issues, an attack on the provisions of the Criminal Code for failure to comply with the constitutional protection extended to pregnant women by section 7 of the Charter. The Court held that section 7 requires both an assessment of the substance of a legislative provision for compliance with guaranteed rights and a review of the provision for conformity to procedural safeguards. Section 7 allows state deprivation of rights only when that deprivation is in accordance with the "principles of fundamental justice."¹³ Section 7 allows a person to control both her physical and mental integrity. The Court recognized that integrity is particularly easily violated in the context of criminalization of conduct. Stigmatization; loss of privacy; stress and anxiety; disruption of family, social, and work life; legal costs; and uncertainty as to the outcome and sanction all interfere with Charter-protected rights. Section 7 protection extends to the psychological impact of state action.

Chief Justice Dickson cites Mr. Justice LeDain in *R. v. Therens*,¹⁴ who wrote, "the element of psychological compulsion, in the form of a reasonable perception of suspension of freedom of choice, is enough to make the restraint of liberty involuntary."¹⁵ He continues:

At the most basic, physical and emotional level, every pregnant woman is told by the section that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations. Not only does the removal of decision making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress ... Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person.¹⁶

Madam Justice Wilson, in her reasons for judgment in the *Morgentaler* case, begins her analysis with a consideration of the meaning of the liberty interest protected by section 7. She quotes from MacCormick that liberty is "a condition of human self-respect and of that contentment which resides in the ability to pursue one's own conception of a full and rewarding life."¹⁷ MacCormick continues, "To be able to decide what to do and how to do it, to carry out one's own decisions and accept their consequences, seems to

me essential to one's self-respect as a human being."¹⁸ The basic theory underlying the Charter is, according to Wilson, that "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."¹⁹ She adds, "Liberty in a free and democratic society does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them."²⁰ With regard to the meaning of "security of the person," Madame Justice Wilson agrees with Beetz and Dickson that the protection extends to both physical and psychological integrity.²¹ She continues, "State enforced medical or surgical treatment comes readily to mind as an obvious invasion of physical integrity."²² She adds that section 251 of the Criminal Code of Canada is of the effect that

the woman's capacity to reproduce is not to be subject to her own control. It is to be subject to the control of the state. She may not choose whether to exercise her existing capacity or not to exercise it. This is not, in my view, just a matter of interfering with her right to liberty in the sense (already discussed) of her right to personal autonomy in decision-making, it is a direct interference with her physical "person" as well. She is truly being treated as a means — a means to an end which she does not desire but over which she has no control.²³

Madam Justice Wilson, in discussing the impact of the requirement that any deprivation of section 7 rights must occur in accordance with the principles of fundamental justice, concludes that "a deprivation of a section 7 right which has the effect of infringing a right guaranteed elsewhere in the Charter cannot be in accordance with the principles of fundamental justice."²⁴ She finds that section 251 violates section 2 protection of "freedom of conscience," concluding that the effect of section 251 "is not only to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one conscientiously-held view at the expense of another." She continues, "Legislation which violates freedom of conscience in this manner cannot, in my view, be in accordance with the principles of fundamental justice."²⁵

This is the constitutional context within which interference with women's reproductive autonomy must be assessed. When we examine more closely the various forms that reproductive impediments take, we will return to the words of these judgments as our constitutional tape measure. It is already clear that there is a pattern here within which to measure state action for constitutional fit.

Deprivation in Accordance with the Principles of Fundamental Justice

The rights granted by section 7 are not absolute. Any measurement determining that state action has overstepped its bounds, as defined in the Charter, only considers the first of three tests for constitutional violation required by section 7.²⁶ Section 7 specifically provides a built-in justification mechanism: a deprivation of the rights of life, liberty, or security may occur so long as it is within the parameters of what the

Charter calls “the principles of fundamental justice.” Thus, when we come to measure state action for constitutional fit in the context of interference with reproductive autonomy, the state may allege that the deprivation occurred, but occurred in accordance with the appropriate safeguards.

The limits on such a constitutional defence are not yet clear. What is clear is that the “principles of fundamental justice” include both a substantive and a procedural element.²⁷ State action may violate the substantive requirements that the action conform to the principles of fundamental justice. Or it may violate the procedural requirements of fundamental justice in the form and manner of its administration.

Madam Justice Wilson suggests in *Morgentaler* that state activity that is a violation of section 7 and is also a violation of another Charter-protected right — such as section 2, “freedom of conscience” — can never satisfy the requirements of the principles of fundamental justice.²⁸ In order to be in accordance with the principles of fundamental justice, the deprivation of section 7 rights may not violate any other Charter right.²⁹

In *Re B.C. Motor Vehicle Act*,³⁰ she had also considered this argument, suggesting that where a limit on a section 7 right has been achieved through a violation of the principles of fundamental justice, no justification of that violation may be made under section 1. In *R. v. Swain*,³¹ she reiterated this view. If this view is to prevail in the Supreme Court of Canada, a violation of section 7 of the Charter will be difficult to otherwise justify.

In measuring an administrative structure for fit with the principles of fundamental justice, the legislature is accorded a certain latitude. The choice of structure is assessed in the context of the interest affected. Choice of structure will not be questionable unless the structure chosen is “so manifestly unfair, *having regard to the decisions it is called upon to make*, as to violate the principles of fundamental justice.”³² Some of the elements of that assessment include whether the requirements of the structure are appropriately connected to the parliamentary objective they are designed to achieve and whether or not the structures are truly necessary to assure that those objectives are met.³³

Section 15: The Scope of Equality Rights

Section 15 of the Charter prohibits discrimination. In particular, it prohibits discrimination on a series of enumerated grounds, including sex, race, colour, and age. Section 15(2) provides specific Charter approval of affirmative action programs as long as they meet the conditions referred to in section 15(2). In measuring juridical interference with reproductive autonomy for Charter compliance, we may find instances where section 15 protection has been violated.

There has been a great deal of thought and discussion about the breadth and impact of the language of section 15. That literature will not be reviewed here. Rather, a brief sketch will be drawn of the scope and parameters of section 15 equality rights, bearing in mind that sex

discrimination is a specifically enumerated category. In *Brooks v. Canada Safeway Ltd.*,³⁴ the Supreme Court of Canada held clearly and decisively that discrimination on the basis of pregnancy or reproductive capacity constitutes sex discrimination in violation of section 15.

In *Andrews v. Law Society of British Columbia*,³⁵ Mr. Justice McIntyre defines the concept of equality in the following terms:

It is a comparative concept, the condition of which may only be attained or discerned by comparison with the condition of others in the social and political setting in which the question arises. It must be recognized at once, however, that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality.³⁶

Justice McIntyre stresses that the discriminatory effect of a law must be assessed as it impacts on the group in question. He continues, "there must be accorded, as nearly as may be possible, an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another."³⁷ He further continues:

I would say then that discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.³⁸

On the definition of equality, Mr. Justice McIntyre writes for the full court. However, Madam Justice Wilson has this to add to the analysis of the scope of the concept of discrimination:

[T]his is a determination which is not to be made only in the context of the law which is subject to challenge but rather in the context of the place of the group in the entire social, political and legal fabric of our society. While legislatures must inevitably draw distinctions among the governed, such distinctions should not bring about or reinforce the disadvantage of certain groups and individuals by denying them the rights freely accorded to others.³⁹

In *R. v. Turpin*, Madam Justice Wilson, writing for the Court, furthers the section 15 analysis. In reviewing Criminal Code provisions that granted the option of trial by judge or jury to persons charged with murder in Alberta but not in other provinces, she reasons that the right to equality requires not only evidence of differential treatment but evidence that the differential treatment occurs in a discriminatory fashion. The determination that treatment is discriminatory requires a review of context:

In determining whether there is discrimination on grounds relating to the personal characteristics of the individual or group, it is important to look not only at the impugned legislation which has created a distinction that violates the right to equality but also to the larger social, political and legal context.⁴⁰

This analysis is used to determine whether the interest advanced is the kind that section 15 means to protect. It is meant to ensure that section 15 rights are given the "broad, purposive interpretation accorded to other Charter rights."⁴¹

Women clearly fall into a group that, in the entire social, political, and legal fabric of our society, has been and continues to be subject to disadvantage. Thus, judicial intervention into reproductive autonomy must be carefully measured against the equality entitlement of section 15.

A distinction based on sex does not necessarily infringe section 15(1). In *R. v. Hess and Nguyen*,⁴² Madam Justice Wilson stated that any distinction made on the basis of sex does not invariably impugn a statutory provision. The examples Madam Justice Wilson uses are that of self-induced abortion, as specific to women only, and sexual penetration, as perpetrated by men only. She concludes that simply because a provision addresses a group that is defined by reference to a characteristic enumerated in section 15 does not automatically create a denial of an equality right in the discriminatory sense required.⁴³ Thus, legislative differential treatment does not necessarily invalidate legislation for Charter violation.⁴⁴

Section 15: Pregnancy Discrimination as Sex-Based Discrimination

Section 15 prohibits discrimination generally. It then enumerates certain characteristics that are suspect as the basis of distinction. Discrimination generally, and particularly on grounds that are analogous to those listed in the section, is prohibited. In addition, the meaning of the enumerated grounds must be interpreted by the courts. For our purposes, one of the key questions would be whether discriminatory treatment that appears to attach to pregnancy or capacity for pregnancy would fall within the prohibited heads under section 15 and under the various provincial lists contained in the human rights codes or analogous legislative documents.⁴⁵

In *Brooks v. Canada Safeway Ltd.*, the Supreme Court of Canada clearly and definitively recognized that discrimination on the basis of pregnancy is discrimination on the basis of sex. Referring to *Andrews* and to the earlier case of *Ontario Human Rights Commission and O'Malley v. Simpsons-Sears Ltd.*,⁴⁶ the Court held that discrimination arises when

an employer ... adopts a rule or standard ... which has a discriminatory effect upon a prohibited ground on one employee or group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other members of the work force.⁴⁷

In *Andrews*, Mr. Justice McIntyre held that

no intent [is] required as an element of discrimination, for it is in essence the impact of the discriminatory act or provision upon the person affected which is decisive in considering any complaint.⁴⁸

In *Brooks*, pregnant women were excluded from the sickness and accident benefits plan, although they were entitled to unemployment insurance benefits available to pregnant workers. The argument made was that this discriminatory entitlement based on pregnancy violated the prohibition against discrimination on the basis of sex. This required a determination that pregnancy discrimination is sex discrimination, a point denied by the Supreme Court of Canada in the earlier case of *Bliss*. Mr. Chief Justice Dickson held that

Discrimination on the basis of pregnancy is a form of sex discrimination because of the basic biological fact that only women have the capacity to become pregnant.⁴⁹

He continues that the purpose of anti-discrimination legislation is

the removal of unfair disadvantages which have been imposed on individuals or groups in society. Such an unfair disadvantage may result when the costs of an activity from which all of society benefits are placed upon a single group of persons ... It cannot be disputed that everyone in society benefits from procreation. The Safeway plan, however, places one of the major costs of procreation entirely upon one group in society: pregnant women. [This form of discrimination is] ... one of the most significant ways in which women have been disadvantaged in our society. It would sanction imposing a disproportionate amount of the costs of pregnancy upon women.⁵⁰

Provincial Human Rights Codes

All of the provincial human rights codes prohibit discrimination on the grounds of sex in the domain in which they operate. All of those codes apply to employment; several invalidate any provincial legislation that contravenes the prohibition on discrimination. In the case of those codes that prohibit discrimination on the basis of sex, that ground would now be held to include pregnancy and pregnancy-related issues, following the decision of the Supreme Court of Canada in *Brooks v. Canada Safeway Ltd.*

Several of the statutes specifically incorporate pregnancy and related issues as inherent in the reference to the prohibition on discrimination on the basis of sex. Manitoba, in its Human Rights Code, amended as a result of the provincial judicial decision in the *Brooks* case, provides that there can be no discrimination on the basis of sex and adopts an expanded definition:

- 9(2) (f) sex, including pregnancy, the possibility of pregnancy, or circumstances related to pregnancy;
- (g) gender-determined characteristics or circumstances other than those included in clause (f).⁵¹

Thus, legislation or actions falling within the scope of the various provincial and territorial codes would be invalidated to the extent that they were discriminatory on the basis of sex or pregnancy.

The New Brunswick government has introduced legislation to amend the province's Human Rights Act to prohibit discrimination on the basis of pregnancy. The amendment recognizes discrimination on the basis of pregnancy as a form of sex discrimination. It states "sex includes pregnancy, the possibility of pregnancy or circumstances related to pregnancy."⁵²

The federal Canadian Human Rights Act provides protection against discrimination in federal undertakings, including employment in federally regulated workplaces. Prohibited grounds for discrimination include sex. This category of discrimination is defined so as to include a specific reference to pregnancy and childbearing.

Criminal Law Provisions Controlling Gestation and Birth

For most of the history of the Canadian union, federal legislative impediments to a woman's control of her reproductive capacity have occupied several provisions of the state's most serious arm of control, the Criminal Code of Canada. One of these provisions, section 251 relating to the therapeutic abortion defence, has most recently been removed by judicial fiat. Another, the prohibition on the sale or dissemination of information concerning contraception, was repealed. The rest remain, although in some cases modified slightly from their nineteenth-century versions. A history of the regulation of women's reproductive capacity is beyond the scope of this study; however, brief reference will be made to criminal code provisions concerning reproduction. As Professor Backhouse has pointed out:

Various waves of legislation expanded the reach of the criminal law until virtually all aspects of fertility control had come under regulation. Motherhood was to be forced upon women, regardless of any choice they might have wished to make to the contrary.⁵³

As early as 1758 and 1792, Nova Scotia and Prince Edward Island passed statutes⁵⁴ providing criminal sanctions for the offence of concealment of the birth of an illegitimate child.⁵⁵ On reception of the criminal law, this English provision was extended to Quebec and Upper Canada. Upon proof that the accused had given birth, the child had died, and there had been an attempt to conceal these facts, the accused was presumed guilty of the offence of infanticide. The penalty for the offence was death.

In 1803, the British provision was repealed and an offence was substituted by which women accused of the murder of their illegitimate children would be governed by the rules of evidence and burdens of proof applicable in other trials for murder. Where the woman was acquitted of infanticide she could, however, be convicted of concealment.⁵⁶ The revised

offence was adopted in New Brunswick, Lower Canada, Nova Scotia, and, subsequently, Upper Canada.⁵⁷

Beginning in 1828 in England and followed by the colonies, the offence of concealment was extended to include both legitimate and illegitimate births. In 1867, at Confederation, the federal Parliament obtained authority over criminal law. It included infanticide in the first consolidation of criminal law. The provision that was adopted was both broad in scope and harsh in penalty.⁵⁸

There continues to be a plethora of birth-related offences in the Criminal Code. These modern versions of the old offences have not changed significantly, and they reflect the criminal law's concerns with legitimacy and the social constructs of morality. The Code continues to contain the offences of infanticide,⁵⁹ of killing an unborn child in the act of birth,⁶⁰ of neglect to obtain assistance in childbirth,⁶¹ and of concealing the body of a newly born child.⁶² A number of abortion-related offences remain as well, although section 251 itself has been held unconstitutional by the Supreme Court of Canada.

Abortion was first made a criminal offence in England in 1803, at which time only those abortions that occurred after "quickening," when the movement of the fetus could first be felt, were penalized.⁶³ The 1803 British Lord Ellenborough's Act⁶⁴ provided the model upon which the various Canadian statutes were based. The language of this act was first replicated in New Brunswick in 1810.⁶⁵ Prince Edward Island adopted similar legislation in 1836.⁶⁶ Newfoundland criminalized abortion in 1837.⁶⁷ In 1841, Upper Canada became the first province to pass legislation outlawing abortion even prior to quickening. In 1842, New Brunswick also eliminated the quickening distinction.⁶⁸ This legislation was extended to Lower Canada in 1859.⁶⁹

In 1867, the federal government achieved jurisdiction over criminal law and adopted broad provisions criminalizing abortion.⁷⁰ As the Dominion expanded, the criminal provisions were extended to Manitoba, British Columbia, and Prince Edward Island.

The 1892 Criminal Code consolidated and expanded criminal law control of women's reproductive capacity. The prohibition on abortion was refined,⁷¹ and a new offence of "killing an unborn child" was added to the Code. Infanticide was at that time treated within the general provisions applying to homicide.⁷² In addition, and for the first time, the 1892 Criminal Code made it an indictable offence to sell or expose for sale obscene material to public view. This offence included anyone who "offers to sell, advertises, publishes an advertisement of or has for sale or disposal any medicine, drug or article intended or represented as a means of preventing conception or causing abortion."⁷³ Only three years after the addition of the prohibition on the sale of contraception, the Criminal Code was amended to provide statutory codification of the principle that husbands could not be convicted of raping their wives. This provision endured until 1983.⁷⁴ The prohibition on the sale and use of contraceptives

endured as a criminal offence until the omnibus reforms of the Criminal Code introduced by the Trudeau government in 1969. The prohibition on abortion endured until struck down by the Supreme Court of Canada in *R. v. Morgentaler*.

Excellent historical work has been done by several Canadian scholars documenting the social motivations for these various criminal prohibitions. The primary motivations have been racist and class-based perceptions of appropriate state population policies. Also significant has been the impact of the consolidation of a medical profession on control of reproduction.⁷⁵ The degree to which Canadian women and men were able to control their fertility despite the Criminal Code prohibitions has also been documented, as has the cost to human health and human lives.⁷⁶

In its report entitled *Crimes Against the Fetus*, the Law Reform Commission of Canada identifies the various provisions described above as "unduly complex in arrangement, unclear in expression, inconsistent with one another and incomplete in treatment of the foetus."⁷⁷ The Law Reform Commission of Canada, in a report designed to revise the criminal law provisions on therapeutic abortion, which was superseded by judicial developments in *Morgentaler*, makes several proposals for a tidying revision of the control of women's reproduction within the framework of the Criminal Code.

The Law Reform Commission recommends that there be no provisions concerning killing in the act of birth, neglecting to obtain assistance in childbirth, concealing the body of a dead child, or supplying noxious things for the purposes of inducing abortion. Adoption of these recommendations would result in the repeal of several provisions of the Criminal Code.⁷⁸ The Law Reform Commission recommends that, in the place of these offences, a general crime of causing fetal harm or destruction should be substituted. This offence would not apply to actions undertaken to save the pregnant woman's life or to protect her from serious injury, nor to acts undertaken with the objective of destroying the fetus during the time (12 or 22 weeks) when abortion would generally be acceptable.

The Law Reform Commission recommends the addition of a general feticide offence to replace the provisions of the Criminal Code whose repeal it suggests. The text that it proposes follows:

(1) Everyone commits a crime who

- (a) purposely, recklessly or negligently causes destruction or serious harm to a foetus; or
- (b) being a pregnant woman, purposely causes destruction or serious harm to her foetus by any act or by failing to make reasonable provision for assistance in respect of her delivery.⁷⁹

The view of the Law Reform Commission of Canada is that the language of the text has been drafted so as to apply only to purposeful behaviour by the pregnant woman and not to reckless or negligent

behaviour,⁸⁰ nor therefore to lifestyle or addiction issues. The various critiques of the report⁸¹ have suggested that this certainty on the part of the Law Reform Commission is misplaced.

I will return to the proposed feticide offence and the implications that it has for juridical interference with gestation and birth in a later discussion. At this date it is uncertain whether such an offence will come forward as a suggested revision to the Criminal Code.

This brief review of those sections of the Criminal Code that impact on women's reproductive capacity suggests that the level of legislative interference with gestation and birth remains as high today as it was in the nineteenth century. Furthermore, regulation through the coercive state power of the criminal law ensures that the potential penalties for non-compliance remain severe.

The implications of criminal law regulating the access to abortions have been well documented.⁸² There is little known of the impact of criminal law regulation on other aspects of reproduction. There has been some suggestion that the prosecution of midwives in British Columbia and Alberta has reduced access to birthing experiences that are not under the direction of a physician. It has also been suggested that at least a partial reason for the exclusion of recognition of midwifery as a health care option in Canada arises from those same impulses that governed the increasing control of access to abortion and contraception.

Experience in the United States indicates that the power of the criminal law remains attractive to those who would control the behaviour of the pregnant woman in the interest of protecting the fetus from the effects of the woman's lifestyle choices or other difficulties. Therefore, the criminal law is often the vehicle of choice for attempts to punish and deter other women from engaging in behaviours that are damaging to the health of their fetuses. As well, the recommendations of the Law Reform Commission of Canada point toward a use of the criminal law as a potential legal tool in regulating maternal behaviour.

Regulatory Control of Workplace Hazards

There have been several areas of concern about the impact of the work environment on the reproductive capacity of women and men. First, it is clear that certain work environments pose significant reproductive health hazards to the women and men whose job responsibilities expose them to harmful substances. Second, we do not know the degree to which sub-fertility rates in the Canadian population can be attributed to workplace contaminants. Determining the extent to which environmental, workplace, genetic, physiological, and other factors interact to result in sub-fertility rates is very difficult. Third, an apparent concern for the protection of reproductive capacity in women and for the protection of the patriarchal nuclear family has often served as the justification for the "protective" exclusion of women from the workplace.⁸³ Policies that exclude women

from the workplace to protect the health of fetuses that they are carrying or may carry in the future protect fetuses at the expense of women's equality rights and access to financially rewarding work.

A study of the discriminatory treatment, albeit "protective," of women in the Canadian workplace is outside the scope of the mandate of the Commission; it has been documented by others.⁸⁴ However, legislative or other provisions that explicitly refer to reproductive capacity in the context of access to employment and continuation of employment fall directly within the parameters of this project.⁸⁵

There have been several recent studies that document the impact of workplace hazards and raise serious concerns about our ability to protect the reproductive capacity of persons working in such environments.⁸⁶ Protection must be provided in a manner that does not interfere with the rights of women to gain access to employment. For the purposes of this study, legislative provisions that directly relate to reproductive capacity will be reviewed. Where, by legislation or by regulation, a worker is treated differently in the workplace because she has the potential to conceive, or is pregnant, interference of the type contemplated by the terms of this project has occurred.

Regulation of exposure to hazardous substances in the workplace is difficult for several reasons. First, exposure levels that are "safe" may be difficult to determine. Second, the cost involved in achieving a zero-risk environment may be perceived as economically unfeasible. In the past, regulation of hazards to the reproductive system has resulted in protective measures being imposed on women in the workplace, and, in particular, those protective measures have been found primarily in industries that are not traditionally associated with women as employees. Similar reproductive risk in female-dominated industries has been the subject of significantly less attention.

In setting exposure levels, greater attention has been paid to the impact of substances on the reproductive capacity of women than to that of men. In some cases only women were studied, even though the workplace environment could well have affected aspects of male reproductive health such as sperm production and motility. Recent literature suggests that the toxicity of substances for male reproductive capacity is an equally serious concern and that studies that focus on the reproductive outcome for women fail to consider that the male partners may well have been the influencing factor in outcomes for the women in question.⁸⁷

Where a woman's access to jobs is limited or restricted because of her reproductive capacity or pregnancy, whether by employer policy, legislation, or regulation, rights to equality in employment are implicated. Charter rights as well as human rights codes are potentially breached. Furthermore, as Professor Katherine Swinton points out, the concept of the "duty to accommodate" as described by the Supreme Court of Canada in *Central Alberta Dairy Pool*⁸⁸ may suggest a duty to meaningfully accommodate women's reproductive experience.⁸⁹

All of the provinces and the federal government provide for a regulatory structure that governs hazards in the workplace. Certain of these regulatory mechanisms impact differentially on women of reproductive capacity or on women who are pregnant or nursing. Often the provisions are found in various codes of practice or in provincial advisory publications. Only rarely are they easily accessible through the acts or regulations governing workplace safety. In addition, for the most part, the author of this report could find no comprehensive collection of workplace regulations that apply specifically to women's reproductive capacity, nor any collection of provisions that might refer to the reproductive capacity of men specifically or of all employees generally.⁹⁰

Thus, an attempt was made to identify all those provisions that might have an impact on reproductive capacity by contacting the provincial departments charged with workplace safety. In this way information was gathered that assists in giving a broad picture of the degree of differential treatment that women are subject to in the Canadian workplace. This list cannot be considered exhaustive, as in most cases the provisions of differential impact on male and female employees could only be identified through a line-by-line perusal of general material forwarded by the various ministries. Furthermore, where the workplace is excluded from the regulatory purview, for instance because of its size or the nature of the activity, differential treatment would be invisible to this sort of a review. It may well be that there are other policies or provisions that are operating to treat women employees differently because of their capacity to gestate.

All of the provincial acts provide for the right to refuse unsafe work under the various occupational health and safety acts. In Ontario, several pregnant women have requested reassignment because of their fear that the environment in which they worked could prove to be hazardous to the health of the fetus. The Ministry of Labour has stated that the act will be interpreted to allow for protective reassignment of pregnant women under such circumstances.⁹¹ As similar provisions are found in all of the provincial and territorial acts, a similar remedy might be available to those pregnant women in other provinces who request protective reassignment.

The legislative policies that could be identified are described here. No specific gender-based workplace directives could be identified with regard to the other provinces or the territories.

Federal Workplace Policies

Regulations under the Atomic Energy Control Act previously provided for differential exposure limits for male and female atomic radiation workers. Under Schedule II of the previous regulations, the allowable level of exposure for atomic radiation workers was 3 rems per quarter year and 5 rems per year. However, a specific allowable dose level for "female atomic radiation workers of reproductive capacity" was indicated in the schedule, allowing only 1.3 rems per quarter and 5 rems per year. The schedule also provided that the dose to the abdomen should not exceed 0.2 rem per two

weeks. However, for persons known to be pregnant, the dose to the abdomen was not to exceed 1 rem during the pregnancy.

Under pressure from the Canadian Human Rights Commission, the regulations were revised in 1985 to provide that all atomic radiation workers were subject to a maximum permissible dose of 3 rems per quarter and 5 rems per annum.⁹² During pregnancy the dose to the abdomen may not exceed a total of 1 rem, accumulated at a rate of not more than 0.06 rem per two weeks. The amended regulation further provides that women who become pregnant while employed as atomic radiation workers must so inform the employer as soon as they become aware of the pregnancy.⁹³

Alberta

Regulations under the Radiation Protection Act⁹⁴ refer specifically to pregnant workers. Section 5 of the Radiation Protection Regulation⁹⁵ requires that the worker inform the employer of her pregnancy as soon as she becomes aware of it. If she is pregnant at the start of employment, she must so inform her employer "forthwith." On disclosure of pregnancy, the employer must ensure that exposure of the pregnant worker "is kept as low as is reasonably achievable."⁹⁶ The maximum exposure level during pregnancy is set at 0.6 millisievert for any two-week period.⁹⁷ Exposure limits for all other workers are set at an annual exposure not to exceed 50 millisieverts.⁹⁸

Nova Scotia

Nova Scotia's workplace is regulated by the Occupational Health and Safety Act.⁹⁹ The act itself makes no explicit mention of reproductive capacity.

Nova Scotia makes non-compliance with codes of practice a violation of the Occupational Health and Safety Act.¹⁰⁰ The *Code of Practice for Working with Lead*¹⁰¹ requires blood lead analysis for all employees exposed to inorganic lead. The tests are required every six months where blood lead levels are under 2.5 $\mu\text{mol/L}$, every two months where blood lead levels are above 2.5, and monthly where the blood lead level is over 3.5. Employees with blood lead levels over 3.5 must be removed from exposure to lead. Employees with levels under 2.5 require no action by the employer. Employees recording a blood lead level over 1.5 who "may be planning a pregnancy" are specifically referred to.¹⁰² In such cases, the employer is directed to

provide health counselling to male and female employees who may be planning a pregnancy. Lead levels above 1.5 $\mu\text{mol/L}$ have been shown to produce such reproductive effects as infertility, increased miscarriages or fetal defects. PREVENT FURTHER EXPOSURE TO LEAD FOR THIS POPULATION (emphasis in original).

However, a letter from the occupational hygienist stated that the "Department of Labour has broad powers to account for reproductive issues in special circumstances" even though the act does not enumerate these powers.¹⁰³

The Nova Scotia Occupational Health and Safety Act incorporates the threshold limit values for chemical substances and physical agents published by the American Conference of Governmental Industrial Hygienists (ACGIH),¹⁰⁴ which in turn incorporate the radiation exposure criteria of the National Council on Radiation Protection and Measurements (NCRP).¹⁰⁵ The NCRP report specifically refers to the occupational exposure of fertile women. The report states that the maximum permissible dose to the fetus from occupational exposure during the entire gestation period should not exceed 0.5 rem.¹⁰⁶ For all other workers the maximum permissible prospective dose equivalent is 5 rems in any year.¹⁰⁷ The comment adds:

The need to minimize exposure of the embryo and fetus is paramount. It becomes the controlling factor in the occupational exposure of fertile women. In effect, this implies that such women should be employed only in situations where the annual dose accumulation is unlikely to exceed 2 or 3 rems and is acquired at a more or less steady rate.

For conceptual purposes the chosen dose limit essentially functions to treat the unborn child as a member of the public involuntarily brought into controlled areas ... the NCRP recommends vigorous efforts to keep exposure of an embryo or fetus to the very lowest practicable level.¹⁰⁸

Ontario

Workplace safety is governed by the Occupational Health and Safety Act.¹⁰⁹ Several of the many regulations issued pursuant to that act refer specifically to pregnancy. Section 9(1)(c) of the regulation respecting X-ray safety¹¹⁰ imposes an obligation on the employer to inform all new employees of the applicable dose limits at the commencement of employment. The allowable dose equivalents are required to be "as low as possible" and are limited to 50 millisieverts annually. If the worker is female, the employer must inform her of the dose equivalent limit for pregnant women. Section 10(2) limits the equivalent dose for pregnant women. Again, the dose is to be "as low as is reasonably achievable," and the *mean* dose equivalent received by the abdomen of a pregnant worker is not to exceed 5 millisieverts during the pregnancy.¹¹¹

The Technical Guide that accompanies the regulation is meant to serve as additional information concerning the health risks associated with exposure of workers to X-rays. Information concerning the impact on the reproductive organs of male and female workers indicates that temporary infertility and permanent sterility in both males and females may result at different levels of exposure.¹¹² In addition, workers are informed that a dose to the embryo in excess of 0.5 sievert "may produce any of a wide range of developmental defects, including malformations, growth retardation and cataracts."¹¹³ The guide also warns that a fetal dose as low as 10 millisieverts may result in mental retardation. An inconclusive risk of childhood cancer associated with fetal X-ray exposure is also referred to.¹¹⁴

Specific mention of pregnancy is made in the guide to the lead regulation.¹¹⁵ Differential exposure limits are provided for workers who are women *capable* of bearing children. A woman who is capable of bearing children must be removed from the workplace when her blood lead levels reach 0.40 mg/L (1.9 µmol/L). She may return to her usual work at the discretion of the physician. Levels requiring action for male workers (or workers who are not capable of bearing children) are significantly more flexible. When male blood lead levels reach 0.60 mg/L (2.9 µmol/L), an inquiry into work practices and personal hygiene must be made. Rising or fluctuating levels or levels that exceed 0.60 mg/L require more frequent monitoring. Levels above 0.70 mg/L (3.4 µmol/L) require that the worker be removed from exposure.

The regulation respecting mercury¹¹⁶ provides that work practices, health status, and personal hygiene should be reviewed when urine levels of 0.15 to 0.2 mg/g creatinine are identified. At levels of 0.2 mg/g, the regulation requires that the worker must be removed from exposure. Return to work may not be permitted until the urine mercury concentration has returned to less than 0.1 mg/g creatinine (0.1 mg/L).¹¹⁷ Section 5, entitled "health education," provides that "exposure of females capable of bearing children should be kept to a minimum."

Saskatchewan

Protection and promotion of workers in Saskatchewan are governed by the Occupational Health and Safety Act.¹¹⁸ There is no specific reference in that act to pregnancy or reproduction. Proposed regulations under the Radiation Health and Safety Act do specifically refer to women of reproductive capacity. Section 4(1)(ii)(e) would require that female workers of reproductive capacity be assessed for radiation exposure on a quarterly basis. Other employees are apparently assessed annually. The allowable level of exposure is specified at a quarterly dose of 12.5 millisieverts for female occupational workers of reproductive capacity. Pregnant women are limited to 10 millisieverts during the remainder of pregnancy, presumably a period of approximately nine months. Other employees are limited to a dose equivalent of 50 millisieverts over a 12-month period.

Section 8 requires that any employee who knows or suspects that she is pregnant must immediately report the pregnancy to her employer or supervisor. Section 9 requires that the employer must reassess her level of exposure and revise her employment duties to ensure that the maximum permissible dose is not exceeded.

In addition to the above specific references, there are four publications of the Ministry of Labour that make reference to women of reproductive capacity. These Codes of Practice and guidelines are not legally binding but would be likely to have an impact on a woman's decision to work in hazardous environments, on an employer's treatment of women employees, and on the advice of physicians consulted by employers or employees with regard to hazardous substances.

The first guide is entitled *Pregnant Women and Hazards of Workplace Chemicals: Technical Backgrounder*.¹¹⁹ The purpose of the document is to summarize the reproductive hazards of substances commonly used in Saskatchewan workplaces and to provide guidance to employers and workers. The pamphlet asserts that there is limited information concerning the reproductive hazards of many industrial chemicals. The pamphlet recommends that the pregnant woman be allowed by the employer to change to other work where possible, if exposure cannot be adequately controlled. The employer is also urged to grant the pregnant worker a leave of absence without pay or loss of seniority on her request, if alternative work is not possible.

The pamphlet then lists some of the general risks associated with various workplace chemicals. There is little emphasis given to the potential reproductive impact on male employees. The information given suggests that the nature of the risk is unknown and therefore precaution should be taken wherever possible. The information provided is extremely general. The tone suggests maternal responsibility to avoid fetal exposure to a degree that suggests that the only safe way to control risk is by withdrawing from the workplace.

A second guide that specifically refers to risks associated with pregnancy is entitled *Antineoplastic Drugs*.¹²⁰ These drugs are used in the treatment of cancer and are toxic to cell growth. Occupational handling of these substances poses a risk to the health and reproductive function of male and female workers. The document refers to reports of a higher risk of spontaneous abortions and malformation in infants among exposed female workers. The report does not indicate whether there is evidence of malformation in the offspring of male workers. This document is significantly more sophisticated in tone than the document described previously. The recommendations contained in the document are meant to serve as guidelines for the employer's obligation to ensure worker safety, outlined in the Occupational Health and Safety Act.

The report contains detailed instructions for containment and control of dangerous substances in the areas of protective equipment, ventilation, and worker training.

Section 6 of the guide refers specifically to pregnancy. The report suggests that where appropriate precautions are taken, reproductive hazards will be reduced. The report recommends that pregnant or lactating workers be transferred, at request, where possible. The report also recommends that a policy with regard to male and female personnel who are actively trying to conceive a child should also be established. It makes no further suggestions as to the form that the policy should take.

A third guide that makes specific reference to pregnant women is the *Recommended Guidelines for Medical Monitoring of Vehicle Radiator Shop Workers Exposed to Inorganic Lead*.¹²¹ This report is addressed to medical personnel and responds to findings by the Occupational Health and Safety Branch that airborne lead exceeded fivefold the regulatory limits in

automobile radiator repair shops in the province. Similar unacceptably high exposure rates were identified in a random sample of workers' blood lead levels. Table 1 of the report describes the reproductive health risks as including stillbirths, miscarriages, possible neurological abnormalities in fetuses of exposed women, and spermatogenesis in men. Biannual examinations of employees are recommended. Blood lead levels that exceed 2.4 $\mu\text{mol/L}$ are considered unacceptable and must be reported to the director of the Occupational Health and Safety Branch. The report suggests that workers who test at this level should be removed from further exposure.

Table 2 indicates threshold levels with regard to impairment of various bodily functions. For disorders of the central nervous, gastrointestinal, haematopoietic, neuromuscular, and renal systems, the levels of correlation between blood lead levels and symptoms are listed as ranging between 2.4 and 4 $\mu\text{mol/L}$, depending on the body system. For impairment to the reproductive system, the tolerable level is indicated as "threshold unknown."

The report directs the employer or doctor to carefully monitor women of childbearing age. Women who are pregnant or who are planning pregnancy are directed to avoid exposure levels that exceed 1.5 $\mu\text{mol/L}$. It is suggested that workers who require removal from exposure be assigned other duties that do not involve exposure. Where temporary absence is the only solution, the report suggests a claim be made to workers' compensation.

Although risks to the reproductive health of men are listed as a consequence of lead exposure, no suggestions for the specific monitoring of male employees or of differential exposure rates for men planning a conception are indicated.

The last guide that makes specific mention of pregnancy is the *Code of Practice for Work Involving the Use of Visual Display Units*.¹²² A Code of Practice constitutes a regulatory directive within the provisions of the Occupational Health and Safety Act and has persuasive power with regard to the standards that may be expected of an employer under the provisions of that act. An infringement of a code is not a violation of the act per se but can be used as evidence in a prosecution of violation of the act.¹²³ The code is indicative of the minimum standard of practice required to achieve the safety and well-being objectives of the act. Employers are free to achieve these objectives in other ways, if they so choose.

Section 5(8) refers specifically to pregnant women. Section 5(8) directs the employer to establish a policy with regard to pregnant operators. It provides that a pregnant worker may request reassignment and the employer must so provide if alternative work is available and possible. If alternative work is unavailable, leave without pay and with protection of seniority must be granted.

Quebec

Unlike the other provinces, Quebec makes specific provision for the protective reassignment of a pregnant worker whose ordinary work environment poses a health risk to her or to her fetus. Section 40 of the Occupational Health and Safety Act includes a specific right to protective reassignment.¹²⁴ A similar provision is available to nursing mothers.¹²⁵ Where temporary reassignment to another work environment is unavailable, workers' compensation benefits are applicable. It is important to note that nothing in this provision makes protection available to men or women who are attempting conception and who feel that their failure or poor outcome reflects workplace hazards. Suzanne Bélanger, in an article describing the strengths and weaknesses of the Quebec scheme, notes other weaknesses.¹²⁶ Among these weaknesses, she notes that the scheme provides no incentive to the employer to improve the health parameters of the environment believed to constitute a risk to the pregnant woman or the nursing mother and child.¹²⁷ She also notes that the delays involved in claiming entitlement to protective reassignment weaken the provision.¹²⁸ In addition, while the right to reassignment is useful for those workers who are unionized, it is less useful for those who are not. Non-unionized workers are more vulnerable to dismissal for exercising their right to protective reassignment. Finally, Bélanger notes that in certain enterprises "des emplois jusqu'à maintenant détenus par des femmes commencent à être transférés à des hommes."¹²⁹

Yukon Territory

The Yukon Territory regulations concerning most hazardous substances contain gender-neutral limitations on workplace hazard exposures. The exposure levels for lead, organic lead, mercury compounds, and radon all refer to the exposure of the "worker"; however, the radiation exposure levels are differentiated on the basis of sex. The *Occupational Health and Safety Regulations Handbook* refers specifically to the pregnant worker and requires that she report the "fact or suspicion" of her pregnancy to her employer.¹³⁰ The maximum permissible dose during pregnancy is limited to 0.1 rad per month during the remaining period of the pregnancy. The regulations direct the employer to "reassess and revise" employment duties so that this dose level may be achieved.¹³¹ The regulations also provide that no person may employ as an X-ray worker any person who is pregnant unless the dose received can be limited in accordance with a table set out in the regulations. That table provides for differential exposure limits for three categories of workers — female workers of childbearing years, pregnant female workers, and all other workers. The restrictions for pregnant workers were described above. Female workers of childbearing capacity are limited to 1.3 rads per 13 weeks and 5 rads per year, compared to 3 rads per 13 weeks for other workers.

Other Provincial Legislation Providing for Differential Treatment of Women

In addition to the legislative provisions in the context of workplace hazards, there have been a limited number of legislative provisions that provide for differential treatment of women or provide for specific recognition of the fetus for particular purposes.

Provisions That Refer to the Fetus

Both New Brunswick and the Yukon Territory have made specific statutory provisions that refer to the fetus. The New Brunswick Family Services Act defines the term "child" to include the "unborn child."¹³² This provision has been used in order to apprehend pregnant women on behalf of the fetuses that they are carrying. There has been no court challenge to this provision, perhaps because the apprehension has occurred in judges' chambers.¹³³ On 15 January 1991, the Chair of the New Brunswick Advisory Council on the Status of Women, Ms. Jeanne d'Arc Gaudet, wrote to Premier McKenna requesting that the provision be amended to preclude the possibility that pregnant women could be apprehended in the alleged interest of the fetus. The Premier's response, dated 13 February 1991, was as follows:

Thank you for your letter advising of Council's concern that, as the definition of "child" in the *Family Services Act* includes an unborn child, this Act could potentially limit a pregnant woman's right.

The main purpose of having the unborn child included in the definition of "child" is to accommodate the Maintenance section of the Act. A legal opinion sought on this matter has indicated that the *Family Services Act* would not provide the authority for a Court to confine or treat a woman against her will.

Although I appreciate your concerns, I am in agreement with the legal interpretation in this matter and do not believe that the definition of "child" in the *Family Services Act* requires amendment.¹³⁴

The Children's Act¹³⁵ in the Yukon provides that the Director of Family and Children's Services may control the conduct of a pregnant woman. The statute provides:

Where the Director has reasonable and probable grounds to believe and does believe that a foetus is being subjected to a serious risk of suffering from foetal alcohol syndrome or other congenital injury attributable to the pregnant woman subjecting herself during pregnancy to addictive or intoxicating substances, the Director may apply to a judge for an order requiring the woman to participate in such reasonable supervision or counselling as the order specifies in respect of her use of addictive or intoxicating substances.

This provision was held to be unconstitutional in the *Joe*¹³⁶ case.

Living Wills

To date, none of the provinces has adopted specific "living will" or advanced health care directives precluding use by pregnant women. Quebec provides for advance directives within the general provisions of the Civil Code. In particular, article 19.3 provides for substituted consent. There is no specific reference to special provisions for pregnant women. The situation in Nova Scotia is the same.¹³⁷ The provinces of Alberta and Manitoba have reports of their respective law reform commissions with regard to advance directives. No specific provisions are made that rely on the status of pregnancy for differential treatment.

In Ontario, a private member's bill introduced in the spring of 1991 contained a special disabling provision during pregnancy. The provision was to the effect that "The living will of a person is not valid while the person is pregnant."¹³⁸

This bill was withdrawn and a package of government bills submitted in its place. These bills do not preclude the operation of an advance directive during pregnancy.¹³⁹

Institutional Policies

Institutional policies that impact on reproductive capacity are often as significant as or more significant than legislative provisions. Policies designed by large institutions with regard to medical care and treatment of women of reproductive capacity or who are pregnant can have a profound effect on the personal and work lives of women. Policies established by employers or employers' associations will probably have a significant impact on large numbers of workers.

Where those policies preclude the hiring of certain employees for certain positions, it may be difficult for those potential employees to realize the discriminatory decision to which they have been subjected and the reasons for it. Where the policies are those of large legal organizations such as the Canadian Bar Association or a medical organization such as the Canadian Medical Association, they may have a profound impact on the decisions of the judiciary, the legislature, and law reformers.

A position taken by organized medicine with regard to the appropriate treatment of pregnant women or women of childbearing capacity will have a profound impact on the course of action that member doctors will take, on hospital policies, and potentially on courts and legislatures. This is the case both in the context of workplace safety and where decisions taken by a woman appear to have a potentially negative impact on the health of current or future children.

In the cases to be examined below in which women's decisions with regard to health care are impugned or contradicted or where women are subjected to criminal charges, the influence of the policies formulated by organized medicine is potentially of great importance.

In Canada, several such policies have been identified, although none of these has as yet been adopted in any formal fashion by the organization engaged in the process of policy formulation. Each organization has the potential for broad influence on the behaviour of its members and therefore the potential for a profound impact on the ways in which Canadians address the issue of risk to women of childbearing capacity. The organizations that have considered policies include the Canadian Chemical Producers' Association, the Canadian Medical Association,¹⁴⁰ the Royal College of Physicians and Surgeons of Canada, and the Canadian Bar Association.

The draft policy of the Ethics Committee of the Canadian Medical Association was submitted to the annual general meeting of the Association held in August 1991. The policy was rejected by the membership at the annual general meeting and referred back to the committee for further consideration.

The draft policy is entitled "The Status of the Human Foetus." It begins by focussing on what it identifies as the unclear status of the fetus.¹⁴¹ The draft policy recognizes the impact that a policy statement by the medical profession can have on what it describes as "issues that cry for resolution."¹⁴²

Furthermore, sooner or later legislation dealing with the status of the human foetus is bound to be developed. Given the realities of the political process, if the profession did not develop and state clearly, in good time, a position on this matter, the legislation that will be developed might not take the medical perspective sufficiently into account. The silence of the profession might be interpreted as an indication that the profession did not care what the law or regulations in this regard might be.¹⁴³

The draft policy focusses on the status of the fetus. It makes a series of recommendations, which, had they been adopted, would have had a profound impact on the practice of medicine as offered to women. The policy recommends that:

Recommendation 1:

A human foetus becomes a person when it meets the criteria for personhood that must be met by all other human beings.

Recommendation 2:

These criteria are met when the foetal nervous system has developed to the point where it has the basic capacity for sapient cognitive awareness irrespective of level of sophistication.

In commenting on this recommendation, the policy elaborates:

In actions that impact on a human foetus, respect for the life of the foetus increasingly has to be balanced against the right to self-determination of the pregnant woman and to the integrity of her person. However, once the foetus has become a person, the ethical deliberations

that are now appropriate no longer consist in a weighing of the value of respect for life of the foetus against the principle of autonomy of the pregnant woman. They now involve a balancing of the right to life against the right to integrity and self-determination. At this point the existence of competing right-claims is no longer at issue. What is at issue is their relative strengths.¹⁴⁴

This recommendation is arguably out of line with current legal understanding of personhood for purposes of legal protection and for entitlement to constitutional protections.

The draft policy continues by stating that the fetus becomes the "ethical equal" of the mother only at 20 weeks. The policy states that the physician must always take the life and welfare of the fetus into consideration when evaluating treatment options for a woman. It cautions that the notion of balancing the competing claims of fetus and woman "does not mean that only passing and token consideration should be given to the foetus. Instead, it means that the reasoning process that leads to a medical decision must attempt a genuine balancing, with serious consideration being given to the foetus as well as to the pregnant woman."¹⁴⁵

The draft policy describes the impact that these principles should have on the everyday practice of medicine. It states that

physicians ought to consider the foetus an object of ethical concern almost from the beginning, and that the foetus should be considered a genuine patient at the latest at twenty weeks gestation.¹⁴⁶

This is the case whether or not the fetus is *in utero*, or in what the draft policy refers to as an artificial environment.

Recommendations 4 and 5 provide that the physician should assume that the fetus is likely to become a person unless there are clear indications to the contrary. When it is certain that this is not the case, then "the physician's obligations towards the foetus are those agreed to by the pregnant woman ... the primary concern of the physician, however, should be the pregnant woman."¹⁴⁷ Contemplated here is a level of health of the fetus so low that the fetus cannot be expected to become a person or will suffer from such a continuous state of ill health as to fall within the term "medical indications for abortion."¹⁴⁸

Recommendation 6 provides that a physician may ethically terminate a pregnancy at any stage where the quality of life of the child if born will be "fraught with irremediable pain and suffering." Where the woman's life is endangered by the continuation of the pregnancy, recommendation 7 provides that the pregnancy may be terminated unless the woman insists that the "life of the foetus should be given priority, then the physician must follow those wishes."¹⁴⁹

The draft policy points out that the optimum situation occurs where pregnancy is wanted and that "mothers" should be "the beneficiaries of appropriate social, economic, and psychological conditions."¹⁵⁰ It then

continues that there may be situations in which a conflict between maternal and fetal interests arises. It gives, as the example of such a conflict, situations in which the pregnant woman refuses to cooperate in medical care designed to benefit the fetus, creates a potentially hazardous environment for the fetus, or refuses a Caesarian section. The draft cautions that the limitations of medical knowledge must be taken into account in these situations, suggests that most of these conflicts can be resolved through education and counselling, and, should the issue be unresolvable, suggests resort to a judicial ruling to determine whether or not the woman's personal integrity and autonomy should be over-ridden in the interest of the fetus.¹⁵¹ It continues:

In emergency cases, where such a judicial review is not possible, the physician has the duty to do what is medically appropriate and possible under the circumstances, in keeping with the reasoning indicated above. In defense of this, the physician may point to the doctrine of emergency, the principle of beneficence, and the fact that the foetus has become a person. Furthermore, the failure to engage in the appropriate and medically indicated action may well constitute an abandonment of the foetal patient.¹⁵²

This reasoning leads to recommendation 12 of the draft policy, which states:

The physician's duty towards the foetus during the third trimester may require that the physician resort to the judicial process in order to try to ensure the survival and wellbeing of the foetus. Such a step should be taken only after due consideration of the gravity of such a step and after all alternatives that are reasonably available have been exhausted. In emergency contexts, the physician's duty is governed by the doctrine of emergency.¹⁵³

The draft specifically suggests that the recommendations of ethical behaviour may not occupy the same parameters as those of legal behaviour.¹⁵⁴ It also argues that there is legal precedent for recommendation 12.¹⁵⁵

The focus of this draft policy is the fetus and the fetal patient. The woman herself is almost entirely absent from the discussion in the text. She appears as the hoped-for recipient of "appropriate social, economic and psychological conditions," and as the person able to insist that, in a situation where a choice must be made between saving her life and the life of the fetus, her own life be sacrificed. She appears as the object of instruction, counselling, and education with respect to possible poor health care choices she may make about the health care appropriate to her fetus. In the event of an unresolved conflict, the physician, cautioned that doctors are not infallible, is to remember the fetus is a patient entitled to protection and is encouraged to apply to the courts for authorization to proceed. The discrepancy between legal and constitutional principles and what are described as ethical principles is seen as not problematic.

This policy, which was not adopted,¹⁵⁶ would have encouraged the medical profession to see the fetus as patient, to think of the fetal maternal

unit as one representing competing interests, to identify the fetus as a "person" with the rights that personhood traditionally grants, and to proceed to the courts where such conflict is unresolved in the view of the physician. Furthermore, the draft policy recommends that should the situation be an emergency, the physician should act — relying on the emergency doctrine as justification.¹⁵⁷ The draft policy encourages juridical interference in gestation and birth, albeit as a last resort.

The Royal College of Physicians and Surgeons of Canada has also prepared a report concerning the physician's responsibility to the mother and the fetus.¹⁵⁸ The report was prepared by the Biomedical Ethics Committee. Impetus for the report was the submission of the College to the Commission. The College is of the view that technological advances and procedural innovations have created a fetus that is "more and more his or her mother's equal in the category of 'patient.'"

In the view of the College, care-oriented counselling has on occasion been replaced by the adversarial process of the legal system:

These legal skirmishes have been rare, but have resulted in needless pain and hostility, criticism in the press and some "bad" court decisions. Legislation is not the proper channel for the resolution of these dilemmas.¹⁵⁹

The report takes the view that, in the absence of autonomy in the fetus, the fetus may properly be regarded as a patient, "especially when it comes to matters of fetal treatment."¹⁶⁰

The report takes a novel approach to the physician's ethical obligations to the pregnant woman:

Unlike the fetus, the pregnant woman has developed her own values and beliefs. These form the basis for her perspective on her own best interest, a perspective that may legitimately differ from that of the physician. The principle of autonomy applied clinically obligates the physician to treat a patient's perspective on best interests always at least of equal weight with the clinical perspective as expressed by the beneficence principle.¹⁶¹

The report continues that, where the view of the physician as to what would be in the best interest of the fetus conflicts with the view of the pregnant woman, the physician "is in a key position to provide counselling and persuasion, but not coercion, to the mother and family who may not share the same view as the physician."¹⁶²

The pregnant woman is more visible in the report of the College than she is in that of the Canadian Medical Association. The College posits a hypothetical case wherein the presenting pregnant patient is a heavy cigarette smoker, an alcohol abuser, and possibly a street drug abuser. The report refers to the dangers both to her health and to the health of the fetus she carries. In commenting on the difficult questions that this example poses for the physician, the report notes:

A healthy intrauterine environment is in the best interests of the fetus. Physicians are caught up in the dilemma of how to provide this when such an environment is absolutely dependent upon another person. Legal interventions have been considered in this regard. Clearly, a legal intervention represents a break-down in the physician-patient commitment. A forceful violation of the mother's ... body for the purpose of assisting the fetus might have some biologic justification but surely the harm done to the mother infant bond here must be considered a major one.¹⁶³

The report also asks some very important questions, including how the physician could reconcile a role as police officer with that of caring and compassionate physician and at what point persuasion becomes coercion of the patient.¹⁶⁴

Unlike the draft policy of the Ethics Committee of the Canadian Medical Association, the report of the College perceives the role of the physician as that of counsellor and advisor to the pregnant woman, who herself is responsible for the decisions with regard to her health care and that of the fetus she carries. The report of the College also gives serious thought to the implications of the use of coercive mechanisms for the role and relationship of physician and patient. That the report of the College eschews coercive intervention is all the more significant in that this conclusion is reached by the authors of the report in the context of an example that raises all of the lifestyle concerns that are so frequently noted in discussions of intervention on behalf of the fetus.

The policy drafted by the Ethics Committee of the Canadian Medical Association may also be contrasted with the conclusions reached by the Canadian Bar Association in their brief to the Commission. In the view of the Canadian Bar Association, whereas "the use of child protection legislation to regulate maternal conduct impinges upon the rights of the mother, use of the criminal law to enforce certain standards of prenatal care is even more chilling."¹⁶⁵ The brief argues that intervention into the conduct of pregnant women, or protection of the fetus, must come from the legislature rather than from the courts. Furthermore, any such intervention requires justification both on policy and on constitutional grounds.¹⁶⁶

In considering the appropriateness of such intervention from a policy perspective, the Canadian Bar Association adopts the position that such intervention would be counterproductive and will deter those women who most need help from attempting to obtain it. The Canadian Bar Association also raises concerns about the race and class of women whose conduct is most likely to be subject to scrutiny.¹⁶⁷ In considering the constitutionality of such legislative intervention, the Canadian Bar Association concludes that forced medical treatment would likely infringe sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*. The brief argues:

Intervention in gestation and birth either by imposing standards of behavior or medical treatment defines women exclusively in terms of

their childbearing capacity: "to deprive women of their right to control their actions during pregnancy is to deprive women of their legal personhood." Imposing duties on pregnant women which are not imposed on other individuals is inimical to the very concept of equality. In particular, equality might demand that society be careful not to demand more of the pregnant woman than parents in general, not single pregnant women out and not impose legal obligations on pregnant women that are out of line with those imposed upon members of society in general.¹⁶⁸

The brief concludes by recommending that legal and judicial intervention in gestation and childbirth be banned.¹⁶⁹ In the view of the Canadian Bar Association, "the difficult cases in which fetuses are truly at risk should be seen as a failure of public policy, medical care and social services and treated as such. The objective is to promote fetal health; regulation and criminalization are inappropriate means to achieve this objective."¹⁷⁰ They conclude their brief with the following recommendations:

- (a) The conduct of pregnant women with respect to gestation and childbirth should not be subject to regulation or judicial interference.
- (b) The conduct of pregnant women with respect to gestation should not be the subject of criminal sanction.
- (c) The fetus should be protected by the provision of medical, social and educational services to pregnant women and to women at risk generally in society.¹⁷¹

The remaining policy to be considered is that of the Canadian Chemical Producers' Association (CCPA). In the "Draft CCPA Guideline on Reproductive and Developmental Hazards in the Workplace," the association is concerned with the risk that chemical, physical, and biological agents present to the reproductive capacity of male and female workers and their effects on the embryos or fetuses of these workers. The purpose of the guideline is to identify reproductive and developmental hazards in the workplace and to identify the actions that should be taken where risks are present. The guideline also points out that the refusal to allow an employee to work on the grounds of pregnancy is not legally acceptable.¹⁷² The guideline also notes that neither workers' compensation nor tort action against the employer is likely to provide recovery for injury to an employee or any child that he or she may bear. Causation is difficult to establish, there is usually no time lost off work, and injury to offspring is not compensated by the various workers' compensation schemes. The guideline also states that although a successful tort action against the employer is unlikely, that possibility has in some cases been used to justify discriminatory hiring policies. In the view of the authors of the guideline, such policies violate human rights and constitute sex discrimination.

The guideline is designed to assist members to identify and deal with hazards in their work environments. It recommends that the employer identify and assess toxins in the workplace, establish an inventory of such

substances, maintain a complete file in a central location concerning these substances, and identify the source of exposure. The employer is encouraged to determine acceptable levels of exposure and to consider the various mechanisms for their control, including elimination or substitution of other substances, engineering controls, administrative controls, changes to work procedures or practices, and the use of protective equipment.

The employer corporation is encouraged to develop a comprehensive hazard communication program advising employees of risks to the male and female reproductive system and of the workplace procedures designed to minimize exposure. This information should be made available to employees in a written format and should be updated as necessary.

The draft guideline recommends that the employer establish a reproductive and fetal protection policy that contemplates the reassignment of persons at risk on an individual basis. Policies that are non-specific, such as those that apply to all fertile women, are discouraged as discriminatory. A blanket policy that extends to jobs that are not in themselves hazardous is also discouraged. Finally, pregnancy testing as a basis for reassignment is discouraged, as risk to the fetus is significant during the first 12 weeks of pregnancy, during which time the pregnancy may not be apparent to the woman.¹⁷³

Judicial Decisions Concerning Interference with Women's Reproductive Autonomy

Case Law Concerning Interference with Reproductive Capacity

In Canada, there have been several judicial decisions that specifically affect women's reproductive autonomy. In each of these cases, an application has been made to a court under one or another legal mechanism in order to impose treatment or lifestyle changes on a particular woman in the interest of the fetus that she is carrying, or her actions prior to birth have been characterized as abuse.¹⁷⁴

These cases demonstrate the range of situations that give rise to a court application, as well as the various legal mechanisms that are pressed into service in order to achieve the hoped-for legal end. One noticeable distinction between the Canadian situation and the American one is that no use has yet been made in Canada of criminal charges in order to penalize maternal behaviour perceived to have had an impact on fetal health.¹⁷⁵ In addition, in only one case has sentencing been used to attempt to provide protection to a fetus.

The Canadian cases providing for imposed treatment in the interests of the fetus are sufficiently few in number such that an attempt to classify them by legal category is of limited assistance. They range from cases that rely on mental health legislation to provide for involuntary committal of the woman in order to provide protection for the fetus, to those that provide for a child welfare apprehension in the interests of the welfare of the child after birth, with remarks from the bench that suggest that some form of

"prenatal abuse" has occurred, to cases in which the health of the fetus is alleged as grounds on which to provide a sentence of incarceration, where one might not otherwise be imposed. With one clear exception, the Yukon Territory ordinance concerning fetal alcohol syndrome, Canadian initiatives in control of maternal behaviour have not taken the form of actual or proposed legislation. Rather, there has been an attempt to rely on existing legislative provisions to cover maternal behaviour and decisions perceived by others to be contrary to the health interest of the fetus.

Canadian decisions that specifically speak to the issue of access to therapeutic abortion will not be included here as examples of judicial interference with reproductive autonomy. While it is possible to characterize an application by a husband or partner to block access to therapeutic abortion as judicial interference with gestation and birth, abortion per se does not fall within the specific mandate of the Commission. Rather, the cases concerning the right of access to therapeutic abortion will be used only to the extent that they shed light on women's right to make other health care decisions in their own behalf. To date, Canadian cases that consider issues of access to therapeutic abortion have supported the right of access, rather than given support to those who would deny access.

Given the small number of these cases in Canada, they will be described in some detail. Excluding cases that were brought to clarify the right to or prevent access to therapeutic abortion, there appear to be only seven cases that raise issues regarding the appropriate judicial response to maternal behaviour perceived as threatening to the fetus. One of these is unreported in the law reports and was identified by Professor Brettel Dawson and discussed by her in a recent article, entitled "Re Baby R: A Comment on Fetal Apprehension."¹⁷⁶

Discussions with various women's organizations and a review of newspaper files have failed to reveal other instances of fetal apprehension or imposed treatment contrary to the pregnant woman's preferences. It is, however, impossible to state with any certainty whether or not instances of coercion by health or social service professionals occur — that is, cases where they do not resort to judicial proceedings.

The first of the reported decisions is that of *Re Children's Aid Society for the District of Kenora and J.L.*,¹⁷⁷ a decision of the Ontario Provincial Court, Family Division. The case involved a wardship proceeding with regard to an infant J.L. J.L. was born suffering from fetal alcohol syndrome resulting from alcohol addiction in the mother prior to and during pregnancy. The mother and the father are described as having no permanent address and as sometimes living on the streets. Four previous children had been made wards of the Crown; two of them suffered from fetal alcohol syndrome. It had been recommended to the mother that she undergo alcohol treatment in Thunder Bay after the birth of the child. When the mother refused, the child was apprehended.

Records entered indicated a history of intermittent detoxification, alcohol-related offences, and hospital admissions for various injuries over

a period of time stretching back to 1977. Notice of the hearing for Crown wardship was served on the mother in the Kenora jail, at which time she was suffering from bruises that she attributed to a beating by her partner. During the duration of the pregnancy, the record before the court showed that the mother received medical care on a regular basis but was suffering from acute alcoholism during the gestational period.

Judge Bradley found that the baby was suffering from fetal alcohol syndrome and that "the fetal alcohol syndrome had been *wilfully inflicted upon J.L. by the mother, C.L., who refused to seek help for her alcohol problem despite the entreaties of Dr. Bevridge*"¹⁷⁸ (emphasis added). The court found that the child was in need of protection at the date of the court application and that the child was in need of protection *prior to birth* within the Child Welfare Act. The physical abuse that the court identified as constituting abuse prior to birth included "excessive consumption of alcohol during pregnancy ... by her neglecting or refusing to obtain proper remedial care or treatment for the child's health, when it was recommended by a legally qualified practitioner."¹⁷⁹

In determining that the child was one in need of protection at the time of apprehension, the court cited the continuing alcoholism of both parents, their lack of housing, and the fact that the relationship is "one marked by physical violence."¹⁸⁰

In making his determination that prenatal abuse had occurred, Judge Bradley relied on the view of Judge David Steinberg, as found in his text *Family Law in the Family Courts*. Judge Steinberg argued that language in the Child Welfare Act referring to "children born or likely to be born outside of marriage" and the definition of a child as "a person actually or apparently under sixteen years of age" could be construed to apply to a child "*en ventre sa mère*."¹⁸¹

It should be noted that the finding of prenatal abuse and that a child "*en ventre sa mère*" could be subject to the Child Welfare Act was admitted by the court to be unnecessary to it as reasons for judgment. The finding that the child was in need of protection after birth was sufficient to ground the apprehension in law.

In the second of the Canadian cases, the issue once again involved an application for apprehension of a child already born, where the court chose to make reference to actions by the mother that occurred prior to the birth of the child and that impacted on the health status of the child at birth. In *Re Superintendent of Family and Child Services and McDonald*,¹⁸² a baby was born to a mother who had been addicted to heroin from the age of 12. Ms. McDonald suffered intermittent addiction to heroin despite several intervals of methadone maintenance therapy. Halfway through her pregnancy, Ms. McDonald consulted a physician who advised that it was too late in the pregnancy to discontinue the methadone treatment without injury to the fetus.

It is clear from the case that Ms. McDonald sought prenatal care throughout her pregnancy. She was seen by a minimum of four doctors

during her pregnancy. The child was born addicted to methadone. The evidence was that the baby's withdrawal was ongoing four months later, at the time of the appeal from a finding that the child was not in need of protection under the Child and Family Service Act of British Columbia. The application to apprehend had been brought on the day that the baby was ready for discharge from hospital.

At the hearing, Provincial Court Judge P. d'A. Collings found that the child was still in the care and custody of the hospital. The baby had not yet been in the care of Ms. McDonald. The judge pointed out that Ms. McDonald had no opportunity to demonstrate her parenting skills.

Apprehension being refused, the child was released to Ms. McDonald and her partner with supervision and support. On appeal, the issue was the correctness of the ruling that the child was not in need of protection. At issue was the meaning of "in need of protection" within the parameters of the act.

On appeal, Judge Proudfoot considered two precise questions. First, whether or not an "unborn child" [sic] could be abused during the gestation period, and, second, whether there was evidence of a clear and imminent danger despite the fact that the child had not yet spent any time in the custody of her mother.

Judge Proudfoot held that "it would be incredible to come to any other conclusion than that a drug-addicted baby is born abused. That abuse has occurred during the gestation period."¹⁸³ She added that there is no necessity that the child actually live at home before such a finding can be made; rather, "the child is born having been abused."¹⁸⁴ She relied on the provision of the act that defines a child as in need of protection where he is "abused or neglected so that his safety or well being is endangered."¹⁸⁵ However, Judge Proudfoot makes it clear that she is not overly concerned with the specific language of the various definitional sections and their precise application:

While the Provincial Court seems to have dwelled on cl.(c) as the basis for the refusal of the order, and I have said earlier that cl.(a) was probably the more appropriate section, to me it makes very little difference on this application. D.J. was born abused ... D.J. falls within the definition under s. 1 as "a child in need of protection," as would any other child born drug-addicted ... the child is born having been abused.¹⁸⁶

Judge Proudfoot relied on the reasons for judgment of the case discussed above, *Re Children's Aid Society for the District of Kenora and J.L.*, as authority, although she paid no attention to the differences in wording in the two acts.

In answering her own second question, Judge Proudfoot referred to evidence from a Dr. Segal concerning neonatal withdrawal syndrome. Dr. Segal alerted the court to the difficulties in caring for an infant suffering from the symptoms of withdrawal. Dr. Segal pointed out that such infants

are highly stressed and often engage in inconsolable crying. The doctor continued that such children stress even the "best of parents" and continued that there is a "common abuse pattern." Judge Proudfoot described the pattern as follows:

It involves a man in the household not the father of the child competing for the mother's affections. In such cases, he [Dr. Segal] says a severe and unending disturbance such as the incessant crying of the baby may invoke an abusive response in the stepfather. Although there may not be any intention to kill the child, nevertheless, very young children are susceptible to dying as a result of relatively minor injuries.¹⁸⁷

Ms. McDonald's partner, identified as a stepfather in the reasons for judgment, is described as manifesting "less than the usual endowment of patience and tolerance, frequently resulting in loss of temper."¹⁸⁸ He "possesses a volatile temper and a fixed rejection of, and opposition to, medical opinion and treatment. As well, he seems to totally dominate the mother."¹⁸⁹

Judge Proudfoot concluded that the child was in need of protection based on the deprivation of care anticipated in the infant's family should she be allowed to return home. An order was entered allowing the child to live at home but imposing a high level of support services, including daily homemaker services, three weekly visits by a community health nurse, and daily visits by a social worker. In addition, the court required that the family could make no overnight visits with the baby, could not take the baby to public places, must continue to reside in Vancouver, and must allow Dr. Segal to have "sole discretion as to the level of support services required to ensure the safety and well-being of this child."¹⁹⁰ This order was made on 13 April 1982. On 14 May 1982, the child was apprehended and removed from the mother's care, albeit supervised. In subsequent hearings concerning custody of the baby, Ms. McDonald withdrew her own application for custody and supported that of her half-brother. On 1 November 1982, in related proceedings, Judge Proudfoot made an order granting permanent custody to the Superintendent of Family and Child Services, refusing to grant custody of the baby to Ms. McDonald's half-brother. This order was appealed to the Court of Appeal of British Columbia.¹⁹¹

In the Court of Appeal, Ms. McDonald is identified for the first time as a First Nations woman, a member of the Nishga Nation. D.J., the baby born addicted to methadone, was, at the time of the appeal, described as "apparently normal and healthy. She is now in a foster home, is doing well and is a candidate for adoption."¹⁹² In her decision awarding permanent custody of the baby to the Superintendent, Judge Proudfoot concluded that the potential future "special needs" of the baby could not be filled by the mother's half-brother. The half-brother, father of five children, lived in a village that was relatively inaccessible and where there would not be access to the specialized care that the child might, at a future date, require. She

found, as well, that Ms. McDonald constituted a particular threat to the baby, that the mother must be kept away from the baby, and that the half-brother might not be able to do so.

Judge Proudfoot concluded that the baby would best be served by placing her in an environment where no one knows of the drug-related past of her grandmother, her uncle (not J.M.) and her mother. To remove that stigma and to prevent the possibility of any future disruption by the re-appearance of her mother, D.J. ought to be placed in a home where she will be separated from and cannot be identified with her past, including the notoriety arising from these proceedings.¹⁹³

At issue in the Court of Appeal was whether the judge had erred in failing to take into account the baby's ties to the Nishga Band and her native heritage. The Court of Appeal found the following:

The ties to the Nishga people are of importance. That is not in dispute. Education and training in the Nishga community and experiencing the Nishga culture would be valuable for D.J. The value of that, however, must be measured against the detriment of placing the child in a position which would make her vulnerable to the mother's unstable character and reputation. The balance on such an issue is delicate and it is one which the trial judge is in the best position to strike.¹⁹⁴

The court upheld the decision of Judge Proudfoot to award custody to the Superintendent and to place the child for adoption.

The next case returns us to the Province of Ontario. In *Re Children's Aid Society of City of Belleville, Hastings County and T et al.*,¹⁹⁵ Canadian courts first encountered an application for protection on behalf of a fetus. Previous cases discussed above had reached conclusions on behalf of existing children at the same time as they commented on and took account of maternal behaviour during pregnancy. The *Belleville* case squarely raised the issue as to whether or not action could be brought by social welfare authorities to control the behaviour of the pregnant woman in the interests of fetal protection. As the child was "unborn," the court characterized the "child" as "still in the obvious and direct care of the child's mother."¹⁹⁶ The conduct of the mother was alleged to place the fetus at risk sufficient so that it could be characterized as a child in need of protection for the purposes of the Child and Family Services Act.¹⁹⁷ In the view of the court, there was sufficient precedent for the court to make an order that a child "*en ventre sa mère*" is a child who can be found in need of protection.¹⁹⁸

The evidence on which Provincial Court Judge Kirkland based his order to apprehend the pregnant woman included evidence of a vaginal discharge "that may or may not be normal,"¹⁹⁹ evidence of abdominal pain or discomfort, erratic conduct, and evidence that the woman spent a night in an underground garage. The judge was also concerned about the pregnant woman's attitude toward the health of the fetus she carried. He said: "I am satisfied that Linda's attitude, whatever may be the cause, is

one which is not conducive to the safe and healthy delivery of the child."²⁰⁰ In the view of the court, the "child" was one who was in need of protection.

In this case, the legal basis for the finding was under provincial mental health legislation.²⁰¹ In the view of the judge, the conduct of the pregnant woman fell within the requirement of the Mental Health Act that the behaviour be a danger to herself. This danger he located in her refusal of health care for abdominal pain and in her spending the night in a cold basement. In his view, the statutory requirement of a mental disorder of a nature or quality that will be likely to result in serious bodily harm had been reasonably shown. Furthermore, in his view the fetus, referred to as a child, fell within the category of "another person," so that there was a reasonable apprehension of causing serious bodily harm to another person. In order to ensure that the "child" be protected in the future, the judge also made an order making the "child" a ward of the Children's Aid Society for a period of three months. He added: "the issue of access to the child may be dealt with further."²⁰²

The *Belleville* case used the provisions of the Ontario Mental Health Act to commit for assessment on an involuntary basis. In the reasons for judgment, more weight is given to the description of the pregnant woman's behaviour given by others including her common-law partner and his sister than is given to the description of her state of health offered by the woman herself. Her counsel argued that she had spent a night in an underground garage as a result of her precarious financial condition.

In the next case to be reviewed, *Re Baby R.*,²⁰³ the application was for permission to proceed to a physically invasive procedure. At issue was a request by the Superintendent of Family and Child Services to proceed to a Caesarian section despite the refusal of the pregnant, labouring woman.

Judge Davis of the Provincial Court of British Columbia allowed the apprehension of a fetus under the Family and Child Service Act. An order was made determining that the fetus was a child in need of protection and granting permanent custody and guardianship to the Superintendent.²⁰⁴

At the time of the apprehension, S.R. was in labour. The baby was presenting in a breech position. The doctor in charge, Dr. Zouves, was of the view that a Caesarian section was called for. S.R. refused her consent. Dr. Zouves contacted a social worker with the Ministry of Social Services. Mr. Bulic, the social worker, reviewed the history and advised Dr. Zouves that he was "apprehending the child ... but that he was not consenting to any medical procedure to be performed on the mother."²⁰⁵ Sometime later, when Mr. Bulic arrived at the hospital, he was informed by Dr. Zouves that S.R. had consented to the surgery. A healthy baby was delivered by Caesarian section. The judge next comments:

The mother's history with children is atrocious. This is her fifth child and she has had only one of them in her care for more than a month. Of the four previous children she had the care of three of them for three days, twenty-three days, and one day respectively. She was incapable of mothering four previous children and anyone with the knowledge of

the past history, coupled with the knowledge of her care for herself during her most recent pregnancy, could only conclude ... She is incapable of parenting a child.²⁰⁶

The court confirms the apprehension, which it justifies as necessary to ensure proper medical attention for the child. Judge Davis adds:

This is not a case of women's rights; Mrs. [R.] consented without coercion or threat to the operation. This case in my humble opinion ought not be a concern for the right to life of the unborn person as suggested in argument by counsel for Mrs. [R.] ... This is simply a case to determine what is best for the safety and wellbeing of this child.²⁰⁷

The decision was appealed to the British Columbia Supreme Court.²⁰⁸ The Women's Legal Education and Action Fund (LEAF) was granted intervenor status on the issue of whether a fetus could be treated as a child within the meaning of the act. The appeal focussed on whether the language of the act allowed for apprehension prior to birth.

Judge MacDonell pointed out that the act defined "child" as "a person under 19 years old." "Person" was not defined by the act. He also commented that while the Superintendent had pointed out that the apprehension order specifically allowed only medical treatment of the fetus, and not any medical treatment of the mother in the absence of her consent, "at the pre-birth stage it is hard to imagine how treatment could be given the child without invading the body of the mother."²⁰⁹ He adds:

No doubt to [the doctor's] relief, the mother did verbally consent to the Caesarian section and there was no longer a dilemma as to what needed to be done, or could be done in the circumstances.²¹⁰

In the view of the Court of Appeal, the last-minute consent to the Caesarian section resulted in there no longer being any issue with regard to the need for an apprehension. The court concluded that there was no factual basis for the apprehension at the time that it occurred, because the woman herself had consented to the treatment that the Superintendent was arguing was essential.

The court stated the precise legal question as whether or not a fetus is a "child" for the purposes of the act and therefore susceptible to a protection order. Judge MacDonell stated:

apprehension of a child after birth is a drastic step to be taken, let alone an apprehension prior to birth. The legislature, with the enactment of child protection legislation, has given the Superintendent of Child Welfare very broad powers of apprehension of a child from his or her parent who, in the superintendent's opinion, is considered in need of protection. The goals are laudable but the powers given are awesome. What the superintendent is given is power well beyond that given in any other body or organization. Such power that the superintendent now has did not exist at common law and could only be authorized by legislation.²¹¹

In determining whether the fetus was an appropriate object for apprehension within the *language* of the statute, Judge MacDonell concluded that there was nothing in the statute that expanded the definition of "child" to include an unborn child [sic], nor that suggested that "person" included an "unborn" child. He points out that, by contrast, the Family Relations Act specifically defines "child" to include "a child not yet born ... but subsequently born alive."

In short, the judge found neither a factual nor a legal basis for the apprehension order and set it aside. Almost a year had passed during which time the child had been kept as a ward of the Superintendent and had not been placed in the custody of her mother.

Finally, the issue of fetal apprehension returned to the Ontario courts in 1990. Again, the application was to take custody of a fetus during pregnancy. The motion sought various categories of relief, in addition to the wardship of the fetus. In *Re A. (in utero)*,²¹² the remedies requested extended to include apprehension of the fetus and an order that the pregnant woman, P.A., receive prenatal care and provide the name of her doctor to the Children's Aid Society, arrange for a hospital delivery and advise the Society of the name of the hospital, and, should she fail to comply with these requirements, be detained at the hospital until her delivery and undergo all necessary medical treatment for the well-being of the child.²¹³

Four of P.A.'s previous children had been made wards of the Society. Furthermore, there is a great deal of evidence in the reasons for judgment that the A.'s had had continuing interaction with the Society and that Mr. A. had a history of engagement with the criminal law.²¹⁴ It is also clear that Mr. A. had a history of violent verbal encounters with Society workers and that Society workers were frightened by him. While P.A. and her husband misled the Society staff as to who was providing Ms. A. with prenatal care, she was receiving prenatal care. The motion to make the fetus a ward of the Society and to make Ms. A. subject to the orders indicated above was an *ex parte* order — that is, one that was proceeding without notice to Mr. and Ms. A. and, therefore, without providing any opportunity for them to be represented by counsel.

Steinberg, U.F.C.J. held that the provisions of the Child and Family Services Act,²¹⁵ which replaced the Child Welfare Act,²¹⁶ contained no language "which would accord to the foetus any status as a person or right to protection under the Act."²¹⁷ In so holding, Judge Steinberg relied on *Tremblay v. Daigle*,²¹⁸ a decision of the Supreme Court of Canada denying an application for an injunction to block access to a therapeutic abortion. As the court concluded there was no jurisdiction to apprehend a fetus within the provisions of the act, it became unnecessary to consider whether or not an *ex parte* order was appropriate.

An alternative argument had been made that the court had a residual common-law jurisdiction under the doctrine of *parens patriae*, within which it could find the authority to act on behalf of the fetus. With reluctance,

Judge Steinberg concluded that he had no such residual power:

The essence of the *parens patriae* power is that the court is empowered to take steps to protect the child or the foetus, *in the place of the parent*. But here the child is actually inside of the mother. It is, therefore, impossible in this case to take steps to protect the child without ultimately forcing the mother, under restraint if necessary, to undergo medical treatment and other processes, against her will. I believe that the *parens patriae* jurisdiction is just not broad enough to envisage the forcible confinement of a parent as a necessary incident of its exercise. Even if it were, however, the court should be very wary about using its powers in such instances, as its routine exercise could possibly lead to some abuse of pregnant mothers (emphasis in original).²¹⁹

Judge Steinberg ended his reasons for judgment with the note that any state interest in providing protection for the fetus in a situation such as this should be exercised by the legislature rather than by the judiciary.²²⁰

The most recent of these cases involved an application under the Family and Child Service Act²²¹ of British Columbia to apprehend a child as "deprived of necessary medical attention" under section 1(d) of the act.²²² The situation in this case was somewhat different from those of the earlier cases we have examined. However, the case raises many of the same questions and concerns that the earlier cases raise, including the issue of family violence and the nature and impact of medical expertise on the determination of conflicts of this nature. Dr. Sydney Segal, who appeared as expert in the *McDonald* case,²²³ again appeared as expert in this case. At issue was the appropriate placement of the child.

Provincial Court Judge Collings characterizes the dispute in the following manner:

does the failure to adhere to Dr. Segal's views with respect to a baby born with demonstrable quantities of cocaine, gravol and possibly methadone in its blood mean that the baby is in need of protection under definition (d) of section 1 of the Family and Child Service Act.²²⁴

The dispute involves a disagreement as to the appropriate care for a child born with some evidence of *in utero* drug exposure.

The child's mother is described as having an experience of addiction from the age of 12 until recently. She is reported as being in her thirties. She has two daughters by a previous marriage who live with their father, but with whom she has kept in regular contact. Her relationship to her older daughters is described by the court as a good one.

The judge describes the most recent pregnancy as a surprise to her. He points out that on discovering the pregnancy she "made an attempt, a quite sincere attempt, to turn her life around."²²⁵ She entered a series of drug programs starting in a detox centre and moving from there to a residential program. She also married her partner. As Judge Collings points out, this was

a mistake which later threatened to undo all the good things, because Blaine (the husband) seems by all accounts ... to be a violent, unpredictable man with criminal and drug problems of his own.²²⁶

The baby was delivered in Abbotsford and was apparently healthy. She had several small anomalies that were considered unrelated to her drug exposure. There was some evidence of cocaine in the blood of the umbilical cord, as well as traces of gravol and possibly methadone. There was little evidence of the symptoms of drug withdrawal, the possible exception being some irritability on the fifth day. She was released from hospital to her mother's care five days after her birth.

The doctor who had presided over the obstetrical care and delivery notified Social Services that the baby was at high risk for abuse at discharge. In indicating the reasons for this notification, the doctor reported:

After discharge, I notified Social Services that this was a baby who was an extremely high risk for abuse. Not only was I unconvinced of Denise's vow to stay off cocaine, *but I was concerned about her husband's, whom she has been married to for one week. He has a history of anger impulse control disorder and has spent time in prison* (emphasis added).²²⁷

The doctor suggested to Social Services that the baby be apprehended and set up an appointment with Dr. Segal. Social Services determined that the baby was not in need of apprehension and arranged to monitor the mother and child. The family then moved to Vancouver where the baby was placed in the care of Dr. Ross. Dr. Ross cancelled the appointment with Dr. Segal and placed the baby under the care of Dr. Peacock, a paediatrician with experience in the treatment of drug-affected infants. Dr. Ross stated her reasons for this decision:

In the medical community, some doctors won't refer to Sunny Hill unless it's a severe case, because Dr. Segal's ideas lead to children being detained and probably apprehended.²²⁸

There is clear evidence that the baby was receiving necessary medical care and that the persons in charge of her care were satisfied with it. The monitoring social worker was also satisfied. However, the mother was being subjected to violence by her husband at home. She is reported as having been beaten on several occasions and as having required hospitalization. There was no evidence that the baby was involved in the violence at home. The court points out that she had support both from her mother and from her two daughters, both teenagers.

Having left the baby in the care of her teenaged daughter, the mother spent the day and evening in Vancouver on 27 July. Subsequently, she reported herself raped and drugged by two men with whom she had accepted a lift home. Her husband beat her in response, and on 27 August he kidnapped the baby. He notified Social Services that he was removing the baby from the mother's custody. The department of Social Services assumed that his description of the events was an accurate one and took

steps to have the baby apprehended. The following day, the mother got an *ex parte* interim order to obtain custody of the baby from Surrey Family Court. The husband showed up on 29 August in Kamloops, where he was arrested and the baby apprehended.

From that time on, the mother had no further contact with her husband and continued in a drug rehabilitation program. She continued to be drug free. Her plan for the child was to live with the baby and the baby's grandmother in an apartment in her brother's house. The grandmother had filed a custody application in the event that the mother was denied custody, so that in either case the baby might live with her mother and grandmother.

From the date of the apprehension on 29 August in Kamloops, the baby spent six months in custody. She was moved through several placements from the end of August to 1 October, when she was moved to a foster home in Vancouver. On 11 October, she was seen by Dr. Segal, who immediately had her hospitalized. Dr. Segal gave evidence to the effect that "her behaviour was so gross that I had to admit her right away."²²⁹ She remained in hospital until 2 November, at which time she was returned to her foster home. As the court points out, the foster home was "not a therapeutic foster home, with specially trained parents — just a good ordinary foster home ... a normal home."²³⁰ Dr. Segal recommended that the baby not be returned to her natural mother, but rather that she be permanently placed.²³¹

The judge comments that there is a tremendous discrepancy between the degree of distress that Dr. Segal describes the baby as having and the specific evidence of those professionals involved in her early care.

It is all very well to talk about the malaise of initial withdrawal she "must have experienced," but all the other evidence indicates no malaise and no initial withdrawal. In my book, direct evidence outranks that sort of "must have been" evidence every time.²³²

The court then reviewed the evidence relevant to the apprehension. Judge Collings concluded that the custody of the child on the day that she was apprehended was rightfully with her mother as a result of the *ex parte* custody order that she had obtained. When the baby was given over to child welfare authorities in Kamloops, she was abandoned by her father. Apprehension of the child at that time was legally appropriate as she was in need of protection from the act of abandonment.

Was the child in need of protection from her mother on the basis of which the apprehension could have been continued? Was the history of drug use during pregnancy, or of the mother's continuing struggle with addiction, grounds on which to remove the baby from her custody? Judge Collings concludes that

The various questionable incidents — the passing out, the alleged rape, the odd drug-taking ... none of this puts the child "in need of protection" by itself — even the drug-taking. It would have to be shown that the

child was deprived of necessary care through the mother being absent or disabled as a result of these incidents.²³³

He continues that there might have been some grounds for apprehension immediately after the birth, based on the mother's use of drugs during the pregnancy.²³⁴ After six months of normal development, there were no such grounds.

Nor was Judge Collings prepared to find that the child was in need of protection from her mother based on an alleged failure to provide medical care, simply because the care she chose was not that approved by Dr. Segal.²³⁵

Thus, after six months, the child, who had been developing normally in the custody and care of her mother, was returned to that care. It is evident that the mother was targeted for surveillance by social services as a result of her drug use, and the impact of partner abuse on the mother was a major factor in the disruption of her life. One reasonable way to describe the events in this case is that the *mother* lost custody of her child for a period of six months because her abusive *partner* absconded with the child and then abandoned her. The personal and financial impact on the mother and the emotional consequences for the baby must have been significant.

There is some evidence of an appropriate use of social services to monitor the baby; there is disturbing evidence of a too-easy impulse to simply remove the baby from the care of her mother and of the inclination of health care professionals to adopt this solution. The confusing evidence offered by Dr. Segal, who appeared to be treating a baby suffering from symptoms that no one else noted and whose course of suggested treatment was identified as contradictory and irrational in the circumstances by Judge Collings, is particularly problematic given his apparent expertise in treating newborns affected by drugs.²³⁶

In the only case in which the sentence imposed on a woman was specifically varied on account of her pregnancy, Judge Hogg of the Ontario Provincial Court sentenced a young woman to 60 days in prison on a charge of communicating for the purposes of prostitution and of failing to appear. She had pleaded guilty to the charge. The sentence that was imposed was well outside that normally imposed in such matters, and Judge Hogg denied counsel's request that she be allowed to serve her sentence on weekends. The young woman, pregnant, also had a four-year-old child at home. She had primary responsibility for the care of the child and informed the court that she was seeking employment.

Professor Dawson quotes from the trial transcript as follows:²³⁷

Prosecutor: I think she appears to be pregnant.

Accused: Yeah, I'm eight and a half months pregnant. I'm 22 years old.

Judge: Eight and a half months pregnant and you're out working the streets? Isn't that lovely?

Accused: That's why I said I didn't have any intention [to continue]. I'm looking for other jobs through unemployment ...

Judge: Where do you live?

Accused: [Address given to a location in a public housing project]

Judge: What a great place to give birth to a child — well known hangout for cocaine dealers, drug dealers and everything else. Isn't that lovely?

Accused: Well, that's where my mom lives; and ...

Judge: Yeah, that's where your mom lives, sure. I'll think about this over recess ... This is an absolute atrocity.²³⁸

In the view of the judge, Ms. MacKenzie deserved incarceration, and incarceration provided a more appropriate environment within which to give birth. No apparent attention was paid to the four-year-old child at home deprived of her mother for two months by this order, nor to the legal appropriateness of such an order.

Only one case deals specifically with the interpretation of legislation of the kind that Judge Steinberg described. In 1984, the Yukon Territory passed legislation under the Children's Act,²³⁹ which provided that

Where the Director has reasonable and probable grounds to believe and does believe that a foetus is being subjected to a serious risk of suffering from foetal alcohol syndrome or other congenital injury attributable to the pregnant woman subjecting herself during pregnancy to addictive or intoxicating substances, the Director may apply to a judge for an order requiring the woman to participate in such reasonable supervision or counselling as the order specifies in respect of her use of addictive or intoxicating substances.²⁴⁰

The constitutionality of this provision was challenged in *Joe v. Director of Family and Children's Services (Yukon)*.²⁴¹ Ms. Joe was a heavy user of alcohol during her pregnancy. She was the subject of an order under the legislative provision quoted above. She complied with the terms of the order prior to the hearing of the appeal.

On appeal, counsel for Ms. Joe argued that the provision of the Children's Act violated section 7 of the *Canadian Charter of Rights and Freedoms*. Judge Maddison held that it violated Ms. Joe's right to liberty as guaranteed by section 7 of the Charter. Several problems were raised. In particular, the term "foetal alcohol syndrome" found in the statute was held to be impermissibly vague. Counsel for the respondent argued that if section 134(1) infringed section 7 of the Charter it could be saved as reasonable under the provisions of section 1 of the Charter. This issue, not having been canvassed at the trial, was held to be untimely for argument at the appeal level.

Case Law Concerning Interference with Reproductive Capacity in the Workplace

The various legislative and regulatory parameters that govern the lives of women of reproductive capacity in the workplace have been described above. In this section, it remains for us to consider the case law concerning differential treatment of women in the workplace at the federal and provincial levels. Where accommodation is not made for women of reproductive capacity or pregnant women, or where women of reproductive capacity are precluded from certain positions, do legal remedies exist?

Federal and provincial human rights legislation prohibiting discrimination on the basis of sex or reproductive capacity plays a key role in the determination of workplace-based conflicts concerned with these issues.

Again, the reported decisions provide examples of the kinds of situations that concern us here. In the earliest reported case that raises the situation with which we are concerned, we find an early example of workplace exclusion policies that affected women of childbearing capacity. In *Re General Motors of Canada Ltd. and United Automobile Workers, Local 222*,²⁴² a grievance was filed against the employer for moving women out of the battery department and for refusing to allow them to transfer into that department. The company had adopted a policy of excluding women from the battery department because of concerns about the impact of lead exposure on women of childbearing capacity.

In a decision by E.E. Palmer, the company policy was upheld. Later decisions, as we will see, have taken a different approach to the legality of such discriminatory policies. However, in the *General Motors* case, the arbitrator took the view that the policy was perfectly reasonable. He begins by saying:

as a general policy of long-standing, the company has excluded females of child-bearing years from excessive exposure to lead. Here one would note parenthetically, but emphatically, that such a policy is clearly reasonable. A perusal of the literature and evidence presented to me clearly establishes this point. Similarly, the mere fact that such a policy merely affects females *per se* does not make such a step "discriminatory." In some areas there are distinctions between the sexes and one can think of no more obvious such difference than in relation to the procreative function.²⁴³

At a late stage in the grievance procedure, the union had taken the position that both males and females of childbearing capacity should be treated similarly in the battery department, as the effect of lead on reproduction was arguably the same for males and females of reproductive capacity. The arbitrator held that both the safety of the fetus of a female employee and the safety of the fetus of the spouse of a male employee were legitimate concerns of the employer where conditions in the workplace might endanger the fetus. In his view, the issue to be determined was whether there existed sufficient grounds for the company to determine that

the risk from lead exposure for female employees was significantly greater than for male employees.

After a review of the evidence presented by the parties, Palmer concluded that there existed clear evidence that the effect of lead on women of reproductive capacity created a greater danger than it did for men. Having found that there existed sufficient evidential support for the company's policy of excluding women, he added:

I am not of the opinion that it has been shown that the company is remiss in not also excluding fertile males from exposure to lead, albeit there is cause for concern. In part, such a conclusion arises from my view that the evidence does not form a basis for such a decision in favour of the union position over that of the company; in part, again, it springs from my reluctance as a layman to make definitive findings in an area where technical skills are vital.²⁴⁴

He then continues by referring to the right of an employee to refuse to work in an unsafe environment. He adds:

I would note that were a male to hold the view that working in such areas is unsafe, such a view would not appear on its face to be an unreasonable one ... [A]n employee may not be disciplined where he refuses to do work which he truly believes to be unsafe where, among other things, such a view is reasonable and validly held. It would follow, therefore, that male employees in their fertile years might well be able to refuse the type of work here in question without fear of discipline ... a reasonable man might reasonably believe such a danger existed.²⁴⁵

The part of the text of the reasons for adjudication that consider the risks associated with lead exposure²⁴⁶ is almost entirely devoted to a discussion of whether or not the risk to males is sufficiently high to justify the exclusion of males of reproductive capacity from the battery area. There is virtually no discussion of the risk to women, except the repeated reiteration that "the effects of exposure to lead on females is quite clear and supportive of the policy formulated by the company."²⁴⁷

The end result of this adjudication was that the grievance of those women who had been excluded from the battery department got little consideration, at least to the extent that consideration was reflected in the reasons for judgment. The company's policy to exclude women was upheld. The adjudicator concluded that the evidence with regard to reproductive risk to *male* employees was one that required a high level of technical skill. Finally, in light of the adjudicator's unwillingness to make a definitive judgment that the battery department posed no risk to male reproductive capacity, he suggested that a request by a male employee for transfer out of an unsafe environment should be so allowed. "[M]ale employees in their fertile years might well be able to refuse the type of work here in question without fear of discipline ... a reasonable man might reasonably believe such a danger existed."

In the second case to deal specifically with workplace exclusion of women of reproductive capacity, *Laurene Wiens v. Inco Metals Company, Ontario Division*,²⁴⁸ Peter A. Cumming, acting as adjudicator, came to a different conclusion under the Ontario Human Rights Code. Inco had adopted a policy of denying employment to women of reproductive age in the pressure carbonyl processing area of its Sudbury plant. In the view of the company, exposure to accidental emissions of nickel carbonyl gas could cause harm to a fetus. Ms. Wiens argued that discrimination on the basis of sex in access to employment included discrimination on the basis of pregnancy or childbearing capacity. The Ontario Board of Inquiry found that Ms. Wiens had been discriminated against in the refusal to consider her as a potential employee in the Inco Pressure Carbonyl (IPC) processing area of the Sudbury plant.

In effect, the policy adopted at the IPC plant was to exclude women of "childbearing potential" from virtually all of the jobs at the IPC plant. This policy had been adopted on the basis of the advice of the medical director at Inco, who was of the opinion that there were "potential health hazards to unborn children in pregnant women both from nickel carbonyl itself and medication given for carbonyl exposure."²⁴⁹

The adjudicator found that there were no known statistics or studies on damage to fetuses from carbonyl gas, nor known problems due to the employment of women of "childbearing potential" in areas in which gas exposure is a risk. Furthermore, he found that the refusal to employ women of childbearing potential had resulted in the denial of opportunity for advancement to Ms. Wiens as well as having precluded her from the opportunity to work occasional overtime.

The law with regard to discrimination provides that the employer who has acted in a discriminatory fashion in violation of the Ontario Human Rights Code may show that the discriminatory policy is required as a *bona fide* and reasonable occupational qualification and requirement for the position or benefit.

Inco took the position that should a female worker be employed at the IPC plant, the company would accede to a request for a transfer away from that unit during pregnancy. Therefore, the risk with which the company was concerned was the risk that the woman would run during the time early in her pregnancy when she might not yet be aware of her pregnant state.²⁵⁰

A great deal of expert evidence was introduced by the parties. Some of that evidence argued that there was little hard information on the exact degree of risk to the fetus from exposure to the gas. Other evidence argued that male and female workers were potentially at the same level of risk with regard to the potential harmful effects of exposure to the gas. Other evidence suggested that, notwithstanding the level of public concern with regard to workplace hazards, there was little evidence of negative outcome clearly associated with normal levels of workplace exposure. At high, or accidental, levels of exposure, there was significant risk to life, of both male

and female employees as well as any fetuses that pregnant female employees might be carrying.

The adjudicator compared the risk associated with exposure to the gas with the ordinary daily risks assumed by pregnant women generally, such as those associated with driving to work or falling while walking on company property. He noted that there is research that conclusively establishes the risk to the fetus of exposure to cigarette smoke, but there is no entitlement to demand a smoke-free workplace. He concludes that risk of exposure associated with nickel carbonyl gas "is a much lesser risk than the other cited situations."²⁵¹ In his view

It would suffice to make females aware of the risk, and require females to state that they practice birth control, and upon their either intending to become pregnant or unintentionally becoming pregnant, requesting a work reassignment beyond the IPC area.²⁵²

The adjudicator held that discrimination on the basis of pregnancy constituted discrimination on the basis of sex within the parameters of the Ontario Human Rights Code. He held this to be the case even though only some women among the class of women get pregnant over their lifetimes. He quoted from Mr. Justice Tarnopolsky to the effect that "it has never been a prerequisite to a finding of discrimination that all members of the class or category be equally affected."²⁵³ He declined to apply the decision of the Supreme Court of Canada in *Bliss v. Attorney General of Canada*, which had held that discrimination on the basis of pregnancy did not constitute discrimination on the basis of sex.²⁵⁴ This decision was over-ruled by the Supreme Court of Canada in *Brooks v. Canada Safeway Ltd.*²⁵⁵ The adjudicator also noted that the Ontario Human Rights Code had also been amended to specifically indicate that discrimination on the basis of sex included discrimination "because a woman is or may become pregnant."²⁵⁶

Once discrimination on the basis of sex had been established, the issue then shifted to determination of the question of whether or not the exclusion of all women of childbearing capacity can be justified by Inco as a reasonable and *bona fide* qualification for working in the IPC plant. A reasonable and *bona fide* qualification must be designed for the purpose of ensuring that the work is performed with dispatch, safety, and economy and must be related in an objective sense to performance of the tasks required in an efficient and economical manner. The safety requirement involves danger to the employee, other employees, and the public. A policy cannot be defended as a reasonable and *bona fide* requirement if the employee claiming discrimination could be accommodated by the employer without "undue hardship." In the absence of proof of undue hardship, measures to provide reasonable accommodation are the employer's responsibility.

Mr. Cumming found that the discriminatory provision did not relate in any way to Ms. Wiens' capacity to perform the jobs at the IPC plant. The exclusion of women of childbearing capacity was not necessary to assure

the efficient and economical performance of the job without danger to the employee, other employees of childbearing capacity, or the public. Nor was Inco's policy of excluding all women reasonably necessary to ensure the protection of the fetus. Rather, Mr. Cumming suggests that a policy precluding pregnant women, or those who are actively attempting to conceive, might meet the test of reasonable and *bona fide* occupational requirement, in the interest of protecting the fetus.

The issue of fetal protection is formulated by Mr. Cumming in two ways. First, he asks whether the employer is placing the fetus at an additional risk to which the employee is entitled to respond. Second, he posits that the issue of assessment of fetal risk is one to be determined by the pregnant woman herself. He questions the validity of the Inco policy:

Although the complainant in this case is not placing herself in danger there is the potential of third party harm but the risk is so small it must be asked whether the exclusionary policy is justified in light of equality objectives.²⁵⁷

He continues:

it is hard to justify the exclusion of almost all women from advancing in employment opportunity because of the small risk that a given female employee might become pregnant without knowing and at the same time be exposed to carbonyl gas.²⁵⁸

He concludes:

Such a small risk does not warrant blanket discrimination on the basis of sex, affecting all women from their early teens until the late forties, and the consequential denial of equality of opportunity in employment. The legitimate concerns of the respondent with respect to fetal risk could be met by providing full information to female employees, recommending the use of a reliable method of birth control, advising against becoming pregnant while employed in the IPC workplace, and providing the option to transfer to a carbonyl-free area of the workplace upon intending to become pregnant, without disadvantage in terms of earnings, benefits and seniority.²⁵⁹

While concluding that Inco's policy discriminates against women and cannot be justified as a reasonable and *bona fide* occupational qualification and while finding pregnancy a condition that the employer must accommodate, Mr. Cumming engages in a balancing of the risk to the fetus, which he finds to be minimal, with the employee's right to employment without discrimination. At no place in his reasons does he suggest that there is not a legitimate interest in the fetus that must be taken into account. However, he does argue that women should be allowed to make their own decisions:

It is more in keeping with equality objectives to allow the individual to make the informed choice of accepting the very slight risk or rejecting the very slight risk in favour of alternative employment.²⁶⁰

Inco was ordered to provide training to the complainant and to discontinue and abandon its employment policy of excluding women from the IPC sector of its operations.

In the most recent case²⁶¹ dealing with the differential treatment of women in the workplace, the employee, Ms. Heincke, sought a transfer out of the spray painting area of the employer, Emrick Plastics, for the duration of her pregnancy. Ms. Heincke worked in a plastics manufacturing plant. The majority of the company's employees were women. When Ms. Heincke learned that she was pregnant, she requested the transfer. Her request was supported by a letter from her doctor. Upon receipt of her request, she was moved to the packing area of the plant, where there were virtually no paint fumes. However, three weeks after the transfer, she was informed that the doctor's note was insufficiently specific. A second note from the doctor was also described by the company as insufficient. The company advised Ms. Heincke to take an immediate leave of absence without pay. Ms. Heincke filed a grievance under the collective agreement, which was left unresolved as the union negotiated a clause in its new collective agreement with the company to cover future situations similar to the one suffered by Ms. Heincke. The clause provided that pregnant employees exposed to substances that cause documented medical problems will be provided with alternative work wherever reasonably possible.

The reasons for judgment make it quite clear that the company would have had no trouble in accommodating Ms. Heincke in the packing area of the plant to which she had been temporarily transferred and where she had performed adequately. New employees were hired for the packing and decorating parts of the company's operation during the period of time when Ms. Heincke was on unpaid leave. Ms. Heincke filed a complaint with the Ontario Human Rights Commission alleging discrimination on the basis of sex. Mr. B. Hovius was appointed as Board of Inquiry. The parties to the complaint agreed that, following the reasons for judgment of the Supreme Court of Canada in *Brooks v. Canada Safeway*, discrimination on the basis of pregnancy would constitute discrimination on the basis of sex in violation of the Ontario Human Rights Code.

In the view of the adjudicator there was evidence of health risks to pregnant women associated with the spray painting area. A rigid refusal to transfer pregnant spray painters effectively would exclude pregnant women from employment at Emrick Plastics and would constitute constructive discrimination on the basis of sex. Therefore, under section 10(a) of the Ontario Human Rights Code, Emrick had a duty to take reasonable steps to accommodate Ms. Heincke once she informed the employer that she could no longer work at spray painting for the duration of her pregnancy. The failure of Emrick to accommodate Ms. Heincke infringed her right to equal treatment with respect to employment without discrimination because of sex as guaranteed by the Ontario Human Rights Code. Ms. Heincke was awarded lost wages, general damages, and interest.

On appeal of the decision of the Board of Inquiry, judges Callaghan, McMurtry, and Campbell upheld the decision of the board. The exclusion of pregnant employees from employment outside the spray painting area constituted constructive or adverse-effect discrimination on the basis of sex and was contrary to the Ontario Human Rights Code.

The court relied on *Ontario Human Rights Commission v. Etobicoke*.²⁶² That judgment decided that, where an employer relies on health and safety considerations in support of the reasonableness of its failure to accommodate, the evidence must be objective. It may not be merely the "subjective, impressionistic, or speculative apprehension"²⁶³ of the employer. The employee may herself be obliged to make some accommodation.

The obligation of the company was to justify Ms. Heincke's exclusion on the basis that it was a reasonable and *bona fide* occupational qualification in all of the circumstances. In this case, the company had received written confirmation from Ms. Heincke's doctor that her employment in the packing area would be sufficient to protect her health status, according to the court:

In essence the company told Ms. Heincke that she could not work because the company disagreed with her obstetrician. It is paternalistic, patronizing and unreasonable for a lay employer, without objective medical evidence, to sit in judgment of the reasonably informed medical opinion a woman receives from her own medical specialist. It is unreasonable for an employer to say that it will simply not accept the opinion of a woman's medical specialist, even though the employer has no objective evidence or medical opinion to the contrary.²⁶⁴

It is interesting to note that one of the demands that the company made of Ms. Heincke was that she obtain a letter from her doctor

that absolves Emrick Plastics and its management from any and all responsibility relating to the health of yourself and your unborn with respect to the air quality in the workplace.²⁶⁵

The court commented on the inappropriate nature of the suggestion that Ms. Heincke's doctor somehow has the authority to absolve the corporation of responsibility to Ms. Heincke:

It would be impossible for any employee to obtain such a letter. Doctors are in the business of providing health care, not in the business of indemnifying their patients' employers against lawsuits. Doctors are not insurers and they give medical care, not legal absolution.²⁶⁶

The court commented that requiring such an indemnification from the physician "detracts unreasonably from a pregnant woman's freedom to make her own reasonably informed employment and medical choices."²⁶⁷ The court did not comment on the insistent emphasis on the pregnant woman and fetus as separate entities, where insistence on the protection of Ms. Heincke's health during pregnancy would have provided appropriate protection.

As there was no evidence of any risk to the fetus from the air in the packing room, the court concluded that it did not need to address whether risk would justify over-riding a decision of the pregnant woman to continue in her employment. However, in raising, but not deciding, this question, the court makes reference to the reasons for judgment of the U.S. Supreme Court in the *Johnson Controls* case.²⁶⁸

Johnson Control's professed moral and ethical concerns about the welfare of the next generation do not suffice to establish a BFOQ [*bona fide* occupational qualification] of female sterility. Decisions about the welfare of future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents.²⁶⁹

The court also refers to language in *Wiens* that was referred to earlier in this paper:

It is more in keeping with equality objectives to allow the individual the informed choice of accepting the very slight risk or rejecting the very slight risk in favour of alternative employment.²⁷⁰

In upholding the decision of the Board of Inquiry, the court made it clear that the company had a duty to take reasonable steps to accommodate Ms. Heincke during her pregnancy, in this case by allowing her to move to alternative employment in the plant. The court confirmed the award of damages.

Summary

There has been a significant level of juridical interference with reproductive autonomy in Canada. The historical interference with women's reproductive lives contained in the Criminal Code of Canada persists today. The Law Reform Commission of Canada suggests that the level of regulation be increased by the addition of a feticide offence. Differential workplace exposure policies continue in several of the provinces despite their contravention of the requirements of the equality provisions of the human rights codes and the *Canadian Charter of Rights and Freedoms*. The occasional legislative provision persists in specifically providing for legislative preference for the fetus in a manner that contravenes human rights code or Charter protections. Canadian courts persist in distorting legal principles in a misguided and counterproductive attempt to ensure healthy births. The Canadian Medical Association, in a proposal referred back to committee, suggests that a policy of maternal over-ride is in the interest of the fetus and is required of an ethical physician although precluded by the legal principles embodied in the human rights codes and in the Charter.

More recently, however, there have been several judicial decisions indicating that there is no legal right to apprehend a fetus or to discriminate on the basis of reproductive capacity. The Canadian Bar

Association has come out against judicial or other over-ride of women's autonomy in the alleged interest of the fetus. The Yukon provision imposing treatment is under study, having been held unconstitutional. Exclusionary workplace policies have been held to violate human rights codes, and the decision to continue in employment has been identified as appropriately the woman's decision.

The appropriate response to concerns about maternal and fetal health and the protection of the reproductive health of Canadian women and men requires an understanding that reproductive capacity in both men and women is equally vulnerable and that within the workplace environment both must be protected. The Quebec provisions with regard to protective reassignment are an important, although partial, beginning. In other contexts, the protection of fetal health similarly requires the protection of maternal health and autonomy through the provision of services sensitive to the lives and experiences of women. Punitive responses are of little use.

In the next part of this study, I will review the American response to similar issues. American legislative and judicial behaviour is often of significant influence on Canada and can serve as a precursor of the Canadian response. In addition, the lessons learned in the United States about the effectiveness of juridical interference with gestation and birth can serve as suggestive for the design of Canadian policy in this area and as indicative of the nature of the recommendations that the Commission should consider.

United States of America

The United States of America has been the site of a great deal of activity that falls within the parameters of interference with gestation and birth. This has occurred in many domains and has been the subject of a great deal of discussion. This section will review the various forms that interference with gestation and birth have taken in the United States, as well as the critique of that experience. In order to do so effectively, this report will first sketch briefly the constitutional parameters against which American law requires that such initiatives be measured. A detailed discussion of American constitutional history and doctrine is far beyond the parameters of this study.

U.S. Constitutional Law

There are two general standards against which any interference with gestation and birth must be measured for constitutional acceptability. The first of these is the protection offered by the Bill of Rights,²⁷¹ the paramount constitutional document of the United States. The second is the legislative protection offered by Title VII of the Civil Rights Act of 1964 and the amendments thereto. In particular, the 1978 Pregnancy Amendment Act²⁷²

repealed a decision of the U.S. Supreme Court and amended the statutory language precluding discrimination on the basis of sex to specifically include discrimination on the basis of pregnancy.²⁷³

Several decisions of the Supreme Court of the United States defend reproductive autonomy through use of the privacy doctrine. These include the cases striking down criminal prohibition on access to contraception²⁷⁴ and proceeding to the various cases defining access to therapeutic abortion. In particular, *Roe v. Wade*²⁷⁵ and *Doe v. Bolton*²⁷⁶ established the right of access to therapeutic abortion based on a woman's constitutionally protected right to privacy under the Bill of Rights. Subsequent cases have continued to define the limits of the right to privacy, as well as the limits of the state's right to intervene in the interest of maternal health and on behalf of the fetus. A great deal of concern has been raised by the court's most recent decision on the issue of abortion.²⁷⁷ Nonetheless, the right to privacy and control of personal health care decisions is within the domain of constitutionally protected autonomy. For this reason, state initiatives interfering with reproductive autonomy are constitutionally suspect.

In addition, the American Bill of Rights provides for an entitlement to equal protection of the law. This constitutional guarantee protects against the loss of privileges to which others are entitled, without due process and procedural protections providing for fairness. Much of this language will find its echo in the discussion above²⁷⁸ of the *Canadian Charter of Rights and Freedoms*.

Most of the states also have constitutions of their own. In many cases, the language reflects the U.S. Constitution. The existence of a state constitution allows additional constitutional checks on state-governed activity. In at least one instance that we will review, the *Johnson Controls* case, the state constitution served in the lower courts as constitutional justification to strike down discriminatory workplace policies.

U.S. constitutional doctrine applies various standards of scrutiny to state action that, on its face, violates the constitutionally protected right to privacy. Where a fundamental right is violated by state policy, as would be the case where criminal sanctions are imposed for behaviour that *prima facie* falls within the protected zone of personal privacy, state action must withstand the test of strict judicial scrutiny and must be justifiable as serving a compelling state interest. It must be designed so as to intrude on constitutionally protected rights as little as possible.²⁷⁹ Criminalization of behaviour, one of the mechanisms chosen often in proposed legislation of maternal behaviour, is one of the most intrusive of state mechanisms.²⁸⁰

The Fourteenth Amendment to the Constitution stipulates the following: "no state shall ... deny to any person within its jurisdiction the equal protection of the laws."²⁸¹ This amendment protects against discrimination on the grounds of sex. In contrast to criminal law interference or classifications on the basis of race, gender- or sex-based classifications are subject only to an intermediate level of judicial scrutiny. They require only that the classification "serve important governmental

objectives and ... be substantially related to the achievement of those objectives" in order to survive an equal-protection challenge.²⁸²

There are two possible levels using equal-protection analysis of state initiatives that interfere with reproductive autonomy over gestation and birth. The traditional analysis imposes a "similarly situated" test to determine whether there has been an unconstitutional violation of the right to equal protection of the law. A court must first ask whether there is a reason for the state to burden one group (women) and not another. If such a reason can be identified, the classification must be shown to be "substantially related" to the objective of the state.²⁸³ An alternative analysis suggests a "gender-neutral test," which requires that, in addition to identifying a difference between men and women permitting different treatment, the state must demonstrate good reasons for not treating men and women identically. The statute in its gender-discriminatory form must further a valid interest that a gender-neutral statute could not.²⁸⁴ Where statutory classification is on the basis of pregnancy, it is now classified as discrimination on the basis of sex for the purposes of equal-protection analysis.

Furthermore, in *Roe v. Wade*, the Supreme Court held that the fetus is not a person for the purposes of entitlement to equal protection under the Fourteenth Amendment.²⁸⁵

Legislative Provisions That Specifically Affect Women's Reproductive Autonomy

An incredible level of activity in the United States appears to manifest a significant level of concern for fetal well-being. It has taken many forms.²⁸⁶ Perhaps most prominent among these activities is the use of legal action against women whose life circumstances, behaviour, or health care preferences are perceived by others to be an inappropriate choice in terms of fetal interest. In these cases, discussed in the following pages, various statutes are stretched from their original legislative purpose and made to fit new circumstances.

The most common of such uses is the distortion of drug trafficking statutes to criminally penalize women who are alleged to have used drugs during pregnancy. These women are said to have delivered drugs through the umbilical cord to the fetus. These statutes that were drafted for other purposes will be referred to where appropriate in the section of this paper discussing the increasing level of litigation against pregnant women. This section will review the various forms of legislative initiatives taken and proposed that specifically concern women of reproductive capacity and pregnant women.

While it is not possible to be certain that all proclaimed or proposed bills have been identified within the 51 jurisdictions of the United States, those described here are representative of the various forms that bills may take in legislative interference with gestation and birth. The George

Washington University Intergovernmental Health Policy Project²⁸⁷ reports that, in 1990, 34 states debated bills concerning prenatal substance abuse. It has also been reported that, in California in 1989, 20 different bills relating to the problem of substance abuse during pregnancy were pending before the legislature.²⁸⁸

Feticide Offences

One significant area of legislative activity that can be identified is the creation of various criminal feticide provisions.²⁸⁹ At least 16 states have enacted feticide offence provisions that allow for prosecution for homicide where a fetus is killed in a criminal attack against a woman. These statutory provisions are allegedly in response to concerns about assaultive behaviour toward pregnant women that additionally causes death or harm to the fetus. The statutory language generally provides that the destruction of or injury to a fetus is a crime like that of homicide toward a person. California and New York specifically include the fetus within the provisions of the general homicide statute.²⁹⁰ California's legislation states, "murder is the unlawful killing of a human being, or a fetus, with malice aforethought."²⁹¹ New York's wording makes reference to viability: "homicide means conduct which causes the death of a person or an unborn child with which a female has been pregnant for more than twenty-four weeks."²⁹²

Minnesota has adopted a comprehensive fetal protection statute, which provides criminal penalties for the intentional murder of a fetus as well as for negligent acts that cause injury to a fetus, including assault of a fetus and injury to a fetus during the commission of a crime. This statute specifically excludes the pregnant woman from its provisions. In the other instances, it is unclear whether or not maternal behaviour could constitute the factual basis for a criminal charge. In light of the use of other criminal statutes to prosecute women for behaviour that *prima facie* would not appear to fall within the scope of the statutes relied upon, it would seem unwise to definitively conclude that women would not be the subject of criminal charges within the purview of the feticide offence provisions.²⁹³

Living Will Legislation

There have been several cases in the United States in which pregnant women have been maintained on life support systems that would have been terminated in the absence of pregnancy. In at least two cases there has been litigation between a party who insists that the life support systems be continued until there are prospects for a safe delivery, while the opposing party pressed to have life supports discontinued.²⁹⁴ In at least one case, access to abortion for a comatose woman, authorized by her husband and believed to be in the interests of her health, was provisionally blocked by a stranger to the family purportedly on behalf of the fetus she carried.

The case law on the "right to die" primarily begins with the decision in the case of *Re Quinlan*.²⁹⁵ Most recently, the right to refuse health care

treatment, even where death will follow, has been confirmed by the U.S. Supreme Court in the *Cruzan* case.²⁹⁶ U.S. jurisprudence on the right to refuse life-saving or life-prolonging treatment recognizes a constitutional entitlement to decline treatment. This right is one that is available to all competent adults, to competent adults by advance directive that continues to operate after an intervening loss of competence, and to people who have always been or who have become incompetent through the concept of a substitute or proxy decision maker. Recognition of the right to refuse health care has found its legal underpinnings variously in the constitutional doctrine of privacy, in state constitutions, in legislation, and in the common-law principle of inviolability of the person.

Many of the U.S. states have developed legislative schemes designed to allow for advance directives in the event of supervening incompetence. These legislative provisions take various forms and are the subject of various definitional limits, depending on the state. They represent the differing judicial responses to the issue of refusal or termination of treatment that occurred in the various states. Legislatures in at least 38 states and the District of Columbia have passed legislation providing a statutory right to an advance directive.²⁹⁷

Of particular interest to this project is the fact that several of these statutory provisions specifically preclude their use during pregnancy, usually by making void any advance directive during a woman's pregnancy. As we will see, this legislative interference with the exercise of a woman's reproductive autonomy finds its judicial echo in the case law refusing to honour a woman's health care decisions on her own behalf and that of her fetus.

Typical of such a provision is that contained in the California statute:
If I have been diagnosed as pregnant, and that diagnosis is known to my physician, this declaration shall have no force or effect during the course of my pregnancy.²⁹⁸

A limited number of the statutory provisions refer to the stage of fetal development in voiding the advance health care directive. Alaska's statute voids the woman's directive only if "the fetus could develop to the point of live birth with continued application of life-sustaining procedures."²⁹⁹ Some state statutes exclude women from other statutory mechanisms available where an advance directive has not been made.³⁰⁰ Some of the statutory language reveals a certain level of confusion. While several of the statutes purport to maintain any common-law-based rights to refuse treatment, suggesting that a pregnant woman might attempt to rely on a common-law right to make her own health care decisions in the face of the statutory language, at least one statute specifically states that nothing in the statute "shall be construed to condone, authorize, or approve abortion."³⁰¹ These statutory provisions often preclude both the woman's right of access to a therapeutic abortion and her right to determine her own health care.

Legislation Encouraging or Requiring Contraception as a Condition of Entitlement to Public Benefits

Several states have introduced bills designed to impose contraception on women as a condition for receiving social benefits. In Kansas, a bill has been introduced tying social welfare payments to the use of the contraceptive "Norplant," a contraceptive device implanted under the skin for up to five years. The Kansas bill provides for

a program to make available the Norplant contraceptive or another functionally equivalent contraceptive which provides similar long-lasting pregnancy prevention ... to each public assistance recipient who is a woman who is able to become pregnant and who is receiving aid to families with dependant children. Each such public assistance recipient who has the Norplant contraceptive, or another functionally equivalent contraceptive, implanted under this program shall be eligible to receive ... \$500 and a special annual financial assistance grant in the amount of \$50 during the period that the contraceptive remains implanted and continues to be effective in preventing pregnancy.³⁰²

A related bill provides that women capable of pregnancy and convicted of a drug-related offence may, as a condition of probation, be required to undergo implantation with Norplant or an equivalent for a period of 12 months. During that time, she must undergo random drug testing. The implant will be removed only after 12 months of random negative drug test results.³⁰³

In a similar proposal, the governor's budget proposal to the Wisconsin legislature includes a pilot program that provides higher social welfare benefits to teenage mothers who marry and penalizes teenage single mothers. The Parental and Family Responsibility Plan places a cap of \$440 per month on social benefits for unmarried women receiving Aid to Families with Dependant Children. This is the current level for a single woman with one dependant. The proposal terminates any increase for single women with more than one child. Married teenage mothers will receive an allowance of an additional \$80 per month for each additional child.

In Louisiana, a measure has been introduced that would provide women on social assistance with a supplemental payment of \$100 per year if they agree to be implanted with Norplant or an equivalent. In Ohio, a Senate committee killed a proposal that would have required women who give birth to infants who test positive for controlled substances to be implanted with Norplant as an alternative to criminal prosecution for trafficking. In Texas, the House of Representatives adopted an amendment to the 1992-93 appropriations bill providing that recipients of Aid to Families with Dependant Children be paid \$300 on implantation of the Norplant device and an additional \$200 if it is left in place for a period of five years. The amendment was initially adopted without debate. Almost immediately the measure was reconsidered and killed on the basis that an appropriations bill cannot be used to change general state law.³⁰⁴

Prenatal Abuse Provisions: Prenatal Abuse as a Criminal Act

Several of the American states have amended child abuse or neglect statutes in order to specifically refer to the actions of pregnant women who are drug users, whether on a single, occasional, or regular basis. In February 1990, 21 states were identified with statutory provisions defining neglect or abuse with specific reference to drugs or alcohol. By way of example, the Illinois statute had provided juvenile court control over a "child in need of services." The act was amended to include an expanded definition of a neglected or abused minor.³⁰⁵ The definition now refers to infants born with a controlled substance in their systems:

(1) Those who are neglected include

(c) any newborn infant whose blood or urine contains any amount of a controlled substance as defined in ... the Illinois Controlled Substances Act, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances, the presence of which in the newborn is a result of medical treatment administered to the mother or the newborn infant.³⁰⁶

Nothing in the statute requires the state to show that the child is addicted or that there have been any harmful effects to the child. The presence of the substance is grounds on which to remove the child from the custody of the mother, who is presumed to be not only guilty of drug abuse, but unfit to parent. A second bill is pending before the Illinois legislature. That bill provides for a new criminal offence specific to pregnant women who are using drugs. The act, entitled "Conduct Injurious to a Newborn," provides the following description of the offence:

Any woman who is pregnant and without a prescription knowingly or intentionally uses a dangerous drug or a narcotic drug and at the conclusion of her pregnancy delivers a newborn child, and such child shows signs of narcotic or dangerous drug exposure or addiction, or the presence of a narcotic or dangerous drug in the child's blood or urine, commits the offense of conduct injurious to a newborn.³⁰⁷

The proposed penalty allows for imprisonment from one to three years.

The bill provides for certain statutory defences:

It shall not be a violation of this section if a woman knowingly or intentionally uses a narcotic or dangerous drug in the first twelve weeks of pregnancy and:

1. She has no knowledge that she is pregnant or
2. Subsequently, within the first twelve weeks of pregnancy, undergoes medical treatment for substance abuse or treatment or rehabilitation in a program or facility approved by the Illinois Department of Alcoholism and Substance Abuse, and thereafter discontinues any further use of drugs or narcotics as previously set forth.³⁰⁸

Similarly, the Indiana Code expanded its definition to include a child born with fetal alcohol syndrome or an addiction to a controlled substance

or drug, or a child "at a substantial risk of a life threatening condition" that arises or is aggravated by a mother's addiction to a controlled substance or alcohol during pregnancy.³⁰⁹ Nevada expanded the definition of child in need of protection to include any child "suffering from congenital drug addiction or fetal alcohol syndrome."³¹⁰ Florida revised its definition of "harm" to include harm to the child's health, including "physical dependency of a newborn infant on a controlled drug."³¹¹ Oklahoma made similar changes, revising the definition of "deprived child" to include "a child in need of special care and treatment as a result of being born in a condition of dependence on a controlled dangerous substance."³¹²

Similar results are obtained by those states that have enacted laws that require public health officials to report women who are known to be using drugs during pregnancy to child welfare authorities. Minnesota requires that pregnant women who are known to be using drugs be reported under the Reporting of Maltreatment of Minors Act.³¹³ The definition of "neglect" has been amended to include

prenatal exposure to a controlled substance ... as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects.³¹⁴

Doctors are required to test pregnant women and newborn infants when medical indications of drug use or withdrawal are present and to report positive test results to the Department of Health.³¹⁵

Oklahoma requires reporting to the Department of Social Services, which may notify the district attorney.³¹⁶ Utah requires the reporting of any child diagnosed with fetal alcohol syndrome or drug dependency.³¹⁷ A bill introduced by Senator Royce of California would have included the fetus within the definition of "child" for the purposes of reporting abuse. The bill, as amended and passed, provided for the following:

The Legislature finds and declares that fetal abuse is a serious problem in California, one which impacts parents, relatives, families, and in particular the unborn child.

The State Department of Health Services shall conduct a study of the scope and impact of fetal abuse, and shall report its findings in a written report submitted to the Legislature no later than January 1, 1990.³¹⁸

In one of the most punitive provisions identified, an Ohio statute provides that drug-abusing women who are unsuccessful in treatment must undergo sterilization.³¹⁹

Some states have taken the view that such legislative activity is improper and counterproductive and have so indicated in their legislation. Rhode Island amended the Maternal and Child Health Services Act to provide outpatient alcohol and drug treatment services.³²⁰ Florida legislation provides that "no parent of a drug exposed newborn infant shall be subject to criminal investigation solely on the basis of such infant's drug dependency."³²¹ The state of Washington increased the funding allocation

available for alcohol and drug treatment programs.³²² New York introduced a bill entitled "An Act to Amend the Civil Rights Law, in Relation to the Rights of Pregnant Women ...";³²³

The legislature finds that the prenatal care needs of women are not being met. The legislature specifically finds: that it is necessary to recognize drug addiction as a disease and to treat such disease medically instead of criminally.

The bill further provides that

no pregnant woman shall be subject to arrest, commitment, confinement, incarceration, or other detention or infringement upon her liberty of whatsoever nature solely for the protection, benefit, or welfare of her fetus.

Drug or alcohol testing of the infant may not be undertaken unless there is specific medical indication of danger to the health or safety of the child. Such an inference "may not be drawn from a parent's race, colour, ethnicity, economic status, type of insurance coverage, or residence."

Congressional Caucus for Women's Issues

The Congressional Caucus for Women's Issues has introduced a comprehensive Women's Health Equity Act, 1991 (WHEA).³²⁴ This package of legislation was introduced on 7 February 1991. Similar legislation was introduced the year before.

The WHEA consists of a package of 22 bills designed to provide a legislative response to the lack of attention to women's health care issues. The bills are directed to issues of research, services, and prevention specific to women's health care.

Included among the various proposed bills are initiatives providing funding for women's health research, to increase the representation of women among senior physicians and scientists, and to develop programs in obstetrics and gynaecology. Other bills ensure the inclusion of women and minorities in research protocols, particularly in the areas of substance abuse and mental health; provide for research on breast and ovarian cancer, contraception, and infertility; and aid research specific to women, as well as osteoporosis and related disorders.

Other bills are designed to ensure an expansion of health care services to women, including treatment choices for breast cancer, adolescent pregnancy prevention, and comprehensive prenatal and post-natal care. The proposed bills tie third-party coverage of obstetrical care to infertility and adoption coverage, extend Medicaid coverage to pregnant women and children under six, and extend Medicaid coverage to include routine mammography and Pap smear screening.

Institutional Policies

Several U.S. medical societies have taken specific positions on interference in reproductive choice within the domain with which we are

concerned. The earliest of these is the position taken by the American College of Obstetricians and Gynecologists (ACOG) in 1987. In an ACOG Committee Opinion, issued by the Committee on Ethics,³²⁵ the College advised against resort to court procedures to over-ride maternal refusal.

The committee described the role of the physician faced with a patient's failure to follow medical advice as an educative and counselling role. In the view of the committee, it is important for the physician to avoid adopting a coercive role, as this violates the principles of informed consent as well as threatening the doctor-patient relationship. Furthermore, physicians are reminded that medical knowledge is fallible. Where the pregnant woman declines to follow the physician's recommendations, the committee advises that she be encouraged to consult other professionals. The report concludes that resort to the courts is counterproductive. Inherent in the report is an assumption that the fetus is a patient, as is the pregnant woman.

The conclusions of the report are as follows:

1. With advances in medical technology, the fetus has become more accessible to diagnostic and treatment modalities. The maternal-fetal relationship remains a unique one, requiring a balance of maternal health, autonomy, and fetal needs. Every reasonable effort should be made to protect the fetus, but the pregnant woman's autonomy should be respected.
2. The vast majority of pregnant women are willing to assume significant risk for the welfare of the fetus. Problems arise only when this potentially beneficial advice is rejected. The role of the obstetrician should be one of an informed educator and counselor, weighing the risks and benefits to both patients as well as realizing that tests, judgments, and decisions are fallible. Consultation with others, including an institutional ethics committee, should be sought when appropriate to aid the pregnant woman and obstetrician in making decisions. The use of the courts to resolve these conflicts is almost never warranted.
3. Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman. The use of judicial authority to implement treatment regimens in order to protect the fetus violates the pregnant woman's autonomy. Furthermore, inappropriate reliance on judicial authority may lead to undesirable societal consequences, such as the criminalization of noncompliance with medical recommendations.³²⁶

Somewhat perplexing is the reference in conclusion 2 to the fact that the "use of the courts ... is *almost* never warranted" (emphasis added). Nowhere in the text is there any suggestion that resort to the courts is ever warranted, nor is there a description of those circumstances in which resort to the courts might be appropriate. It may be that this sentence was added

to the report simply out of an excess of caution, to leave some room for the unimagined example, or the clause may leave space for possible future legislative requirement of resort to the courts, although the report argues against such action.

A similar statement was also issued by a group composed of the California Medical Association, the Southern California Public Health Association, and the California Division of ACOG. This statement was released at the time of the prosecution of Ms. Stewart in California, discussed later in this paper. It provides:

While unhealthy behaviour cannot be condoned, to bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate.

Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination. This failure to seek proper care or to withhold vital information concerning her health could increase the risks to herself and her baby.³²⁷

The most recent representation of the opinion of organized medicine around the issues of maternal autonomy is that adopted by the delegates of the American Medical Association at its Annual Meeting held in June 1990.³²⁸

The conclusions of the American Medical Association are to the same effect as those of ACOG three years earlier. The report takes the view that court-ordered treatment would violate the principles of informed consent and the constitutional entitlement to protection of bodily integrity. The report also argues that the decision to bear a child is one that is constitutionally protected. Forcing a woman to undergo health care procedures against her will would constitute an impermissible burden on that protected right.

The report distinguishes between a woman's moral and her legal obligation, pointing out that while there is a moral obligation for a woman who chooses to carry a pregnancy to term to make reasonable efforts toward preserving fetal health, there is no legal obligation to do so, and the report argues against imposing any such legal obligation. In the view of the American Medical Association, courts are inappropriate forums in which to resolve these issues:

Decisions made under these immediate deadlines and intense pressures are likely to be hasty and lack well-reasoned conclusions. In the case of an improperly reached conclusion, there is no meaningful appeal available.

In addition, such court proceedings may be unfairly weighted against the pregnant woman. A woman in such a situation is probably under considerable psychological stress and may be suffering from substantial physical pain as well. Her ability to articulate her interests may be

seriously impaired. It is further unlikely that the woman will be able to find adequate counsel on such short notice, and it is even more unlikely that counsel will have time to prepare properly for the hearing.³²⁹

The report points out that court-ordered obstetrical intervention is more often sought where the woman is a member of a visible minority or where she is from a lower economic background, where the care is being offered at a teaching hospital, and where the woman is on public assistance.³³⁰ It is inappropriate for physicians to allow themselves to be used as agents of the state.

The report concludes that the physician's duty is to assist the woman in arriving at a decision on her own behalf and that of her fetus. Physicians should refrain from applying to the courts to coerce a decision to accept treatment. The report addressed the issue of those exceptional circumstances in which access to a court order might be appropriate and defines them as follows:

If an exceptional circumstance could be found in which a medical treatment poses an insignificant — or no — health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should be a control in all cases that do not present such exceptional circumstances.³³¹

The report then provides advice as to what response physicians should make to behaviour perceived as harmful to the fetus. The report reminds physicians that there are a variety of legal substances that adversely affect the fetus, including cigarettes, alcohol, over-the-counter drugs, and hazardous chemicals. In the view of the report, "the legal and social acceptance of alcohol make its use particularly difficult to prevent."³³²

The report argues against incarceration or detention during pregnancy and points out that health care services for pregnant women in the prison system are clearly inadequate and that drug use is not prevented by imprisonment. The report is also opposed to the use of criminal sanctions to either cure drug dependency or prevent continuing abuse. The American Medical Association has previously taken the position that "addiction is not simply the product of a failure of individual willpower."³³³

The report also argues against the use of tort or civil liability by injured offspring against their mothers. Arguing against the imposition of liability is the fact that, unlike other situations of civil liability, the pregnant woman and her fetus "share a physical interdependency that a third-party tort-feasor and the fetus do not."³³⁴ Imposition of liability would severely restrict the woman's freedom to behave in "even normally innocuous ways."³³⁵

Many women who behaved in an acceptable manner during pregnancy would be unfairly subjected to liability proceedings, just as presently

many physicians who practice good obstetrical medicine are subjected to unfounded liability claims.³³⁶

The report further notes the difficulties of establishing causation of injury and the fact that the trial process would require "intense scrutiny of the most intimate details of a pregnant woman's life."³³⁷

The report concludes by recommending education and substance abuse treatment programs as the most appropriate response to the problems of addiction in pregnant women. Among the recommended steps are identification of women who are at high risk, early medical and psychotherapeutic intervention, and social and health care needs programs. The report also notes the absence of available spaces in treatment programs and the fact that those limited spaces that are available are in programs designed for use with adult males.³³⁸ These programs are designed neither to meet women's treatment needs nor to provide the additional services that women require, such as day-care and partner-assault counselling services.

The report also considers the issue of the existence of exceptional cases in which it might be appropriate to impose civil or criminal sanctions. Pointing out that such cases would be rare in the extreme, the report also notes that deliberately harmful behaviour to injure the fetus would also injure the pregnant woman herself. The more appropriate response to the self-infliction of deliberate injury to the fetus by the woman would be to provide therapy for her self-destructive behaviour.

The recommendations of the American Medical Association are as follows:

1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.
If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.
2. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
3. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
4. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
6. To minimize the risk of legal action by a pregnant patient or an injured child or fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.³³⁹

While the American Medical Association's position paper is both the most recent and the most thorough of the reports, what is most noteworthy about the positions taken by U.S. formal medical societies is their remarkable uniformity. All three take the position that resort to the legal system in its various coercive forms is wholly inappropriate.

The American Academy of Pediatrics (AAP) has adopted a similar policy that "punitive measures taken toward pregnant women, such as criminal prosecutions and incarceration, have no proven benefits for infant health."³⁴⁰

Judicial Decisions Concerning Interference with Reproductive Autonomy

There have been a number of areas, and an increasing number of instances, in which U.S. courts have reached decisions that interfere with gestation and birth. These cases fall generally into the categories of imposed treatment, criminal charges related to maternal behaviour, cases that consider the conduct of the pregnant woman relevant to a determination of "prenatal abuse" or to a finding that a child is in need of protection, and legal contests to determine whether or not cardiac and respiratory function should be maintained where brain function has ceased, solely to assist fetal development and delivery. There are many of these cases reported in the literature, only some of which are published and available in the law reports. Many are unpublished and probably unnoticed. Only a bare minimum have been appealed to higher courts, from which careful reasons for judgment may be anticipated. In many cases, the impetus for an appeal cannot be expected to exist, because the order will have been implemented and the treatment imposed or child apprehended. Most of these cases involve women whose resources do not allow them to engage meaningfully in their own defence.

These cases will be discussed briefly, rather than in the detail used in the description of the decisions of the Canadian courts. The sheer volume of these decisions makes it impractical to attempt a detailed description, as does the fact that the decisions emanate primarily from courts of first instance. Nonetheless, it is important for the reader to bear in mind that the volume of these decisions is high and shows no signs of abating. Rather, new forms of legal action are even now being created. The American Civil Liberties Association reports that in the first six months of 1990 South Carolina prosecuted 18 women for criminal neglect arising from

drug use during pregnancy³⁴¹ and that 60 such cases have been filed since 1986.³⁴² These actions have been taken despite the position adopted by organized medicine, described above, that such actions are inappropriate.

Imposed Treatment

The cases that concern treatment imposed over the objections of the pregnant woman are among the earliest instances of judicial interference with gestation and birth. They first raised the concerns of legal commentators about the appropriateness of a judicial over-ride of a maternal decision to decline treatment. In addition, the earliest of these cases were decided before the U.S. courts had begun generally to define the right to decline medical treatment and to struggle with the application of those principles to situations involving people no longer or never competent to speak on their own behalf. Finally, it is in the area of imposed treatment that we find one of the most recent appellate-level judgments concerning the appropriateness of court-ordered treatment of the pregnant woman.

The earliest cases involved forced blood transfusions over religious objection of the woman, ordered in the interest of her existing children³⁴³ or in the interest of the fetus that she carried.³⁴⁴ Other cases ordered the pregnant woman to undergo a Caesarian section despite her religious or other objection.³⁴⁵ In at least one of these cases, the procedure was performed.³⁴⁶ In another, the pregnant woman defied the order to attend at the hospital and gave birth vaginally elsewhere.³⁴⁷ One case, overturned on appeal, ordered a pregnant woman to undergo a "purse-string" surgical procedure designed to allow her to "hold" the pregnancy.³⁴⁸ Most recently, in *Re A.C.*,³⁴⁹ a Caesarian section was imposed on a pregnant woman dying of cancer, in a futile attempt to save the fetus. This case was overturned on appeal, after the death of both mother and child.

The *Re A.C.* case represents the clearest authority on the right of the courts to insist on intrusive medical treatment in the absence of the consent of the pregnant woman herself. Angela Carder was diagnosed with cancer at the age of 13. She underwent multiple surgical procedures and extensive radiation and chemotherapy treatments. At 27, she married and, while the cancer was in remission, she became pregnant. At 15 weeks, she was enrolled in a high-risk pregnancy unit because of her medical history. At 25 weeks, she reported back pain and shortness of breath and was found to have had a recurrence of cancer that was diagnosed as terminal.

In consultation with her doctors, there was discussion of the possibility of performing a Caesarian section at 28 weeks. In the interim, Ms. Carder agreed to palliative care designed to extend her life to the twenty-eighth week of the pregnancy and to provide pain control. The palliative care chosen increased the risks to the fetus.

Very quickly Ms. Carder's condition deteriorated. She was only intermittently conscious and had to be intubated. For this reason, she was unable to speak aloud and, when able to communicate, could do so only by mouthing words.

At this point in time, the fetus was twenty-six and a half weeks and was evidencing distress. The hospital proposed to perform a Caesarian section, alleging that the fetus had a greater chance of survival if delivered immediately. It was acknowledged that because of Ms. Carder's medical history and recent treatment, the survival prospects of the fetus were less than would otherwise be expected in a fetus of that age. Ms. Carder's prospects for survival were estimated at 24 to 48 hours.

The hospital applied to the court for an order allowing them to proceed to a Caesarian section without Ms. Carder's consent. There was conflicting testimony regarding the capacity of Ms. Carder to make the decision to accept or decline a Caesarian, given her heavy level of sedation. There was also conflicting testimony as to whether or not, when asked to consent to the Caesarian section, Ms. Carder had responded yes or no, and whether if she had, she had been competent to do so. The lower court found that it was not clear what Ms. Carder's intent was and ordered that the procedure be performed. A stay pending appeal was denied, and the surgery occurred. The baby lived only a few hours; Ms. Carder died two days later.

On appeal, the Court of Appeal ruled that a pregnant woman has a constitutionally protected right to make health care decisions on her own behalf and on behalf of her fetus. The role of the court is to determine whether or not the patient is competent to make her own health care decisions:

Whenever possible, the judge should personally attempt to speak with the patient and ascertain her wishes directly, rather than relying exclusively on hearsay evidence, even from doctors.³⁵⁰

If the patient is incompetent and the court has made a finding to that effect, which it must first do, the appropriate next step is to use the mechanism of a substituted judgment.

Under the substituted judgment procedure, the court as decision-maker must substitute itself as nearly as may be for the incompetent, and ... act upon the same motives and considerations as would have moved her.³⁵¹

The test is primarily a subjective one, an effort to determine what the patient would have done if competent, and weight is to be given to the previously expressed wishes of the patient. The Court of Appeal makes reference here to the fact that Ms. Carder had previously accepted intrusive medical procedures, had chosen to become pregnant and to protect that pregnancy by attendance at the high-risk clinic, and had accepted a treatment plan that included the possibility of a Caesarian at the twenty-eighth week. She also chose palliative care, which increased the risks to the fetus. The role of the court is to inform itself of the condition, prognosis, and treatment options as the patient would do.³⁵² The trial court failed to follow the substituted judgment procedure.

The Court of Appeal adds that

in virtually all cases the decision of the patient, albeit discerned through the mechanism of substituted judgment, will control. We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional. This is not such a case.³⁵³

The application by the hospital to the court for an order to allow the Caesarian section was brought without consultation with Ms. Carder's husband or family. The court order approving the procedure was made over the objections of both Ms. Carder's family and her treating obstetrician.

Following the decision of the Court of Appeal, litigation claiming deprivation of human rights, discrimination, wrongful death, malpractice, and other claims was resolved in an out-of-court settlement in favour of Ms. Carder's family and estate. Part of the settlement required development of policies at the hospital level affirming the autonomy of pregnant patients and incorporating the decision of the Court of Appeal that "in virtually all cases the question of what is to be done is to be decided by the patient — the pregnant woman — on behalf of herself and the fetus."³⁵⁴

The American Civil Liberties Association has reported that 23 applications for court directions to treat pregnant women to protect their fetuses have been brought in the decade leading up to the settlement in the Carder case. More recently, a Wisconsin Circuit Court judge ordered a Caesarian section for a 37-year-old Hmong woman whose seventh child was due on 15 December 1990. In facts that repeat those in the *Jefferson v. Griffin Spalding* case,³⁵⁵ Ms. Lee's physician applied for a court order to perform the surgical delivery, alleging that the placenta was blocking the birth canal, that there was a 90 percent chance that the fetus would die during vaginal delivery, and that there was a 50 percent chance of mortality for Lee. Hmong tradition views Caesarians as threatening the soul and as grounds for the husband to leave his wife. An earlier consent was withdrawn by Mr. and Ms. Lee after family pressure caused them to reconsider. An order was issued but was not implemented because the medical prognosis changed.³⁵⁶

The issue of racism and of class and cultural bias that the *Lee* case raises are inherent, although not often noted, in virtually all of the cases that involve judicial intervention in gestation and birth. In a key article published in the prestigious *New England Journal of Medicine* in 1987, the racism, class bias, and cultural insensitivity evidenced by these court applications were clearly identified.³⁵⁷

In a national survey, the authors received responses that identified 36 attempts to over-ride maternal refusal of certain health care services in a five-year period. Post-birth orders and orders for maternal transfusions

were excluded, resulting in 18 cases. Eighty-one percent of these 18 cases involved women of black, Asian, or Hispanic origin. Forty-four percent of the women were unmarried, and 24 percent had a mother tongue other than English. All were seen at a teaching hospital (rather than a private hospital) or were receiving public assistance. Maternal competency to consent was established in 15 percent of the cases and was not investigated in the others. The article describes one case in which a Nigerian man and his wife refused a Caesarian section for weeks prior to delivery. When the wife went into labour, the husband was physically removed from the hospital. He committed suicide a few months following the court-ordered surgical delivery.

The article argues forcefully against application to the courts to override maternal refusal and warns against the class, race, and cultural biases of those applying for such orders. The article has been widely cited and, perhaps because of the multiple disciplines of its authors, has been influential in the formulation of policy by organized medicine. It is more difficult to argue that the courts of the various states, or for that matter the legislators, have been as attentive.

Criminal Charges

One of the forms that judicial interference into gestation and birth has taken has been an increasing number of criminal charges levelled against women for actions by them during pregnancy. The American Civil Liberties Association reports 60 criminal charges filed against women for use of drugs during pregnancy since 1986. It should be noted that charges for possession or for trafficking are not included in this number and may, of course, be laid against women, pregnant or otherwise. One of the earliest is the case of Pamela Rae Stewart, decided in California in 1987.³⁵⁸

Ms. Stewart was charged with violating a child neglect statute that specifically included a child "conceived but not yet born" within its definition of "child."³⁵⁹ Ms. Stewart was charged in connection with the birth of her third child. At the time, she and her husband lived in a motel room with their two daughters. Ms. Stewart arranged for prenatal care during the third trimester. She was diagnosed as suffering from placenta previa.

Sometime later, Ms. Stewart began bleeding heavily and was taken by ambulance to a hospital, where she consented to a Caesarian section. The child was born with severe brain damage and died six weeks later. Eight months after the birth of the child, Ms. Stewart was charged with child neglect.

The legislative history of the provisions under which she was charged revealed that the definition of "child" was amended in 1923 to include the fetus. This was done to ensure financial support to women during pregnancy, not just after the birth of a child. Ms. Stewart was charged because she allegedly failed to follow her doctor's advice. This advice included that she stay off her feet, refrain from sexual intercourse, not take

illegal drugs, and go to the hospital as soon as she experienced any bleeding. The prosecutor alleged that on the day of the child's birth, Ms. Stewart had had sexual intercourse and that she had failed to go to the hospital for 12 hours after bleeding commenced. He also alleged that traces of amphetamines were found in the baby's system. In his argument, the prosecutor argued that "fetuses are people too. The defendant's rights do not outweigh the fetus's right to life."³⁶⁰

Judge Amos of the Municipal Court, County of San Diego, threw out the charges on the grounds that they had been laid under an inappropriate statute. At the same time, he called on the legislature to enact a bill to protect the life of the "unborn." Ms. Stewart was represented by the American Civil Liberties Association.

The position of the California medical associations, described above,³⁶¹ was drafted in response to the prosecution in *Stewart*. The case attracted a great deal of comment and critique,³⁶² and the response of at least some states was to draft legislation to specifically provide for criminal liability for prenatal behaviour.³⁶³ Despite the critical response to prosecutions by members of the health care professions, the level of prosecutions has remained high.

More recently, numerous charges have been filed against women for delivery of drugs to the fetus. In general, the theory has been one of delivery through the umbilical cord in the moments following birth, before the cord is cut.³⁶⁴ The first woman convicted under such a theory was Jennifer Johnson, convicted for delivery of cocaine metabolites to two infants born within 14 months of each other. A cocaine addict, Ms. Johnson had attempted to obtain prenatal care and drug treatment during her pregnancies and had disclosed her addiction to all health care professionals in order to ensure the best outcome possible for her pregnancies. Nonetheless, she was charged under the delivery statute. The case is under appeal. Among the many arguments that are being made on Ms. Johnson's behalf is that the conviction interferes with the protected right of autonomy in reproductive decision making and is punishment for continuing her pregnancy, offering her a choice either to abort or to face criminal prosecution.³⁶⁵

Most often, unless the state in question has redrafted its legislation in order to refer specifically to drug use by pregnant women, the charges involve a distortion of statutory language.

Since 1986, some 60 criminal cases have been brought against women for drug use during pregnancy.³⁶⁶ Few have proceeded to the appellate level. In April of this year, the Michigan Appeals Court rejected a lower court decision that Ms. Kimberley Hardy should stand trial for delivery of drugs through the umbilical cord to her newborn infant prior to birth.³⁶⁷ The court held that "to prosecute for *delivery* of cocaine is so tenuous that we cannot reasonably infer that the Legislature intended this application" (emphasis in original).³⁶⁸ The provision under which Ms. Hardy was

charged is generally applied to drug traffickers and carries a maximum penalty of 20 years in prison and a \$25 000 fine.

Where specific legislation has been drafted, its constitutionality is seriously doubtful. Recently, a Massachusetts Superior Court dismissed an indictment against a pregnant woman for the specific crime of distributing cocaine to a minor, holding that a statute designed to punish pregnant women for their addictions is a "regulation limiting a woman's reproductive choice" and must be justified by a compelling state interest. While the court recognized the state interest in the late-term fetus, it found that the state "may effectuate its stated interest through less restrictive means, such as education and making available medical care and drug treatment centers for pregnant women." It added,

the common law in no way supports a criminal prosecution of a fetus against its mother. Rather, the common law has traditionally recognized mother and fetus as one entity ... There is no familial bond more intimate or more fundamental than that between mother and the fetus she carries in her womb. This court will not permit the destruction of this relationship by the prosecution.³⁶⁹

In Wyoming, charges were laid against Diane Pfannenstiel. Ms. Pfannenstiel, mother of two children, had been married for three years to a man who abused her. When she appeared at the police station to file charges and admitted to police that she had been drinking alcohol, she was arrested for child abuse.³⁷⁰ Alcohol, it must be noted, is not an illegal drug. The charges were eventually dropped.

Rather than slow the impetus to various forms of prosecution, the National District Attorneys Association, through its American Prosecutors Research Institute, scheduled a two-day workshop to encourage the prosecution of pregnant women with drug addiction problems.³⁷¹

Child Welfare Proceedings

In addition to charges against pregnant women for failing to follow medical advice and for delivery of drugs to their newborn children, charges have been laid for criminal abuse arising out of the use of drugs by pregnant women. While some states have amended their child abuse and neglect statutes to specifically refer to the fetus, in other states the courts have ruled that existing statutory language does not refer to the fetus.³⁷² Many states have used existing child abuse statutes to bring apprehension procedures at birth.

Traditional child welfare procedures are designed to identify those children who are at risk of serious abuse or neglect and to intervene in the least intrusive and disruptive fashion. Generally, a history of abuse or neglect of prior children may be used as indicative of a risk to a child newly born into the family. At issue in these cases is the degree to which evidence of prenatal drug use is, *per se*, evidence of abuse or neglect³⁷³ or a predictor of future abuse or neglect. In several cases, the courts have concluded that the fact that the infant is born intoxicated is probative of

present neglect, without the necessity for any further documentation of current risk within the family.³⁷⁴ In other judgments, the courts have clearly held that evidence of drug use is insufficient and that current danger to the child must be proved.³⁷⁵

By becoming pregnant, women do not waive the constitutional protections afforded to other citizens. To carry the Law Guardian's argument to its logical extension, the State would be able to supersede a mother's custody right to her child if she smoked cigarettes during her pregnancy, or ate junk food, or did too much physical labour or did not exercise enough. The list of potential intrusions is long and constitute entirely unacceptable violations of the bodily integrity of women.³⁷⁶

Like the forced treatment cases, criminal prosecution cases raise serious concerns about the choice of the target population. In a survey by the American Civil Liberties Association of 52 defendants in drug-related cases, 35 were African-American women, 14 were white women, 2 were Latino women, and 1 was a Native American woman. In those states with the highest level of prosecution, the proportion of women charged who are women of colour runs at almost 100 percent.³⁷⁷ Poor women of colour are most vulnerable to state interference with reproductive autonomy, as they are more likely to be already under the auspices of various state services, are unlikely to have adequate health care and prenatal care, suffer from seriously substandard housing and nutritional resources, and are therefore the least able to meet middle-class white standards of mothering.³⁷⁸

It is important to bear in mind that while poor women of colour are the subjects of surveillance and criminal charges, there is no evidence to conclude that other women are less likely to engage in the forms of behaviours on which the prosecutions are based.³⁷⁹

U.S. research indicates similar drug use levels across race and economic lines, as well as similar rates of drug use among patients of private and public medical services. Nonetheless, reporting rates were 10 times higher for women of colour.³⁸⁰ In Pinellas County, Florida, results of a survey indicated that 26 percent of drug users were black women. At the same time, 90 percent of prosecutions were brought against black women. Professor Dorothy Roberts argues persuasively that the constitutionality of state action cannot be assessed without taking into account the race of the target group.³⁸¹

Another use of the criminal law to interfere with reproductive autonomy arises in the sentencing of women whose reproductive conduct is perceived by the state as questionable. Several courts have suggested that "protective" incarceration is appropriate where women charged with offences are pregnant, as a (misplaced) suggestion that prison provides a safer environment for the fetus she carries. In a Washington, D.C., case,³⁸² a woman who had pleaded guilty to cheque forgery of \$700 was sentenced to jail for the duration of her pregnancy. The judge determined that the woman was a drug user and stated:

I'm going to keep her locked up until the baby is born because she's tested positive for cocaine when she came before me ... She's apparently an addictive personality, and I'll be darned if I'm going to have a baby born that way.³⁸³

The concept of prison as a safer place for the fetus is misplaced. There is some evidence that incarcerated women have been coerced to abort³⁸⁴ and clear evidence that incarcerated pregnant women receive inadequate medical and prenatal care. Rates of miscarriage, developmental delay, and infant death are significantly higher than the national average rates among imprisoned populations. Stefan reports that the rate of miscarriage for a particular California jail is 73 percent after the twentieth week of pregnancy, 50 times higher than the state average rate.³⁸⁵ Only one in five pregnant inmates delivered a live baby.

The abrupt withdrawal of drugs is as hazardous to maternal and fetal health as is the continuation of drug use. Completely inappropriate treatment of pregnant women has been reported, including harassment, inappropriate work requirements, and deliberate delay in providing needed care. Two cases have been filed alleging violation of the constitutional rights of pregnant women in the prison system.³⁸⁶ Drugs are as available in jail as elsewhere.³⁸⁷

The use of an order to use contraception as a condition of release is another form in which state interference with women's reproductive autonomy has been manifested. A 17-year-old black woman was convicted of manslaughter for smothering her newborn baby and sentenced to 2 years of imprisonment and 10 years of probation. One of the conditions of the 10-year probationary period was that she use contraception.³⁸⁸ In California, a condition of probation requiring the implantation of "Norplant" for a period of three years was imposed on Darlene Johnson as a condition of sentence for child abuse. This order is under appeal.³⁸⁹ In Ohio, a bill has been proposed that would create a crime of prenatal neglect and require drug-addicted women to choose between jail and procreation. Any woman who is a repeat offender would be able to choose between a tubal ligation or a five-year contraception program. If she is unable to remain drug-free for a period of five years, the judge must sentence her to sterilization. If she refuses to make a choice, she is subject to a possible 25-year prison sentence.³⁹⁰

Mental Health Legislation

Other judicial techniques have been utilized as the basis of interference with gestation. In some cases, women have been incarcerated under mental health legislation, particularly where women have stopped taking psychotropic medication during pregnancy.³⁹¹ In *Re D.K.*,³⁹² an order had been entered against a woman diagnosed as suffering from schizophrenia, restraining hospital personnel from treating her with any medication potentially harmful to the fetus and prohibiting access to abortion for the mother. On appeal, the court determined that the

appointment of a guardian for the fetus had been inappropriate and that the order was unconstitutional, choosing as it did a non-viable fetus over the woman. However, the court did suggest that once the fetus was viable, it might be necessary to appoint a guardian to it.³⁹³

Comatose or Vegetative Conditions

In one of the more bizarre manifestations of judicial interference with gestation, women who show limited brain function have had their life system functions maintained in the interest of maintaining their pregnancies. In a limited number of cases, primarily referred to in the medical literature but in some cases the subject of litigation, women in a persistent vegetative state and women who are brain dead have been maintained solely in an attempt to bring their pregnancies to term.³⁹⁴ In the absence of pregnancy, the appropriate response to treatment decisions on behalf of women who are in a persistent vegetative state or who are brain dead is to follow any advance directives that they have formulated or to allow a substitute to make a decision as to health care options on their behalf.

There have been several cases reported that did not result in litigation, and where we must assume that health care decisions were made by advance directive or by a substitute decision maker. Jordan refers to several of these, collected in 1988. There have probably been others since. Among the cases reported in the medical literature and not involving litigation, he identifies several involving women in a coma or in a persistent vegetative state. These include a 28-year-old woman who suffered from a heart attack and was maintained in a persistent vegetative state for 14 weeks until delivery at 34 weeks, a vegetative woman maintained from the sixth to the thirty-fourth week,³⁹⁵ a woman in a coma delivered of a healthy baby two weeks later,³⁹⁶ the delivery of a healthy baby after the mother had spent six months on life support,³⁹⁷ and a birth following four months on life support. Cases reported concerning brain-dead women include a woman who was maintained for nine weeks until a healthy delivery³⁹⁸ and a baby delivered in the twenty-fifth week of pregnancy five days after the brain death of its mother.³⁹⁹

At least five cases have required litigation to determine the appropriate course of action. In *Petit v. Chester County Hospital*,⁴⁰⁰ litigation was necessary to determine that the guardian of a pregnant comatose woman was entitled to consent to an abortion believed to be in the interest of her recovery. In *Dinino v. State ex rel. Gorton*,⁴⁰¹ a woman sought to attack the provision in the state's living will legislation precluding the application of natural death legislation to women who were pregnant. The court refused to recognize the controversy as justiciable where the applicant was neither pregnant nor incompetent at the time of the legal action. More recently, in *University Health Services, Inc. v. Piazz*, the court held that public policy of the State of Georgia required the maintenance on life support systems of a brain-dead woman "so long as there exists a reasonable possibility that

the fetus may develop and survive, regardless of the state of viability of the fetus.⁴⁰² Authority for this proposition was identified in the existence of an over-ride in the living will legislation as it applies to pregnant women, in the existence of a feticide statute that made killing a quickened fetus a crime, and on the fact that once the pregnant woman is brain dead her constitutionally protected right to privacy no longer exists. This last proposition is particularly suspect. The case law with regard to advance directives and substituted consent suggests that the decision to terminate life support in the event of brain death through the use of a substitute or an advance directive is a manifestation of that very right to privacy. Litigation in the *Piazz*i case was required because Ms. Piazz's husband instructed the hospital to disconnect life support when she had been determined to be brain dead. A second man, whose claim to be the father of the fetus was not disputed, joined the hospital in its request to maintain life supports. Ms. Piazz was in her nineteenth week at the time of the petition. Three weeks after the court order, the fetus went into distress and was delivered by Caesarian section. It died within 48 hours. Ms. Piazz's life support systems were disconnected after the Caesarian delivery.

In the most recent case that I identified, a woman who had suffered serious brain damage in an automobile accident was 17 weeks pregnant. Her husband and family wished to follow the advice of her physicians that an abortion might assist in her recovery. The family decision was contested by strangers purporting to act on behalf of the fetus. The court held that there was no legal basis on which to appoint a guardian to the fetus prior to viability. In refusing the application, the court added that:

Ultimately, the record confirms that these absolute strangers to the Klein family, whatever their motivation, have no place in the midst of this family tragedy.⁴⁰³

The Angela Carder case, discussed above, makes it clear that the pregnant woman's right to determine the course of her health care continues even in the event of intervening incompetence.⁴⁰⁴

Workplace Exclusion

In March 1991, the Supreme Court of the United States handed down its decision in *U.A.W. v. Johnson Controls, Inc.*⁴⁰⁵ The court held that a workplace exclusion policy that precluded assumedly fertile women from certain areas of the employer's operation constituted sex-based discrimination within the parameters of Title VII of the Civil Rights Act. This decision was the culmination of several years of litigation arising out of "protective" policies that impeded women of reproductive capacity from participating in certain work environments to protect the fetus from the impact of hazardous substances in the workplace.

Fetal protection policies are a recent addition to a long history of employment policies that, in the name of "protection," precluded women from employment opportunities.⁴⁰⁶ In a brief review of the historical motives for protective legislation, Professor Mary Becker⁴⁰⁷ identifies several

assertions to justify the exclusion of women. Among these she lists that the work was too taxing, that night shift work was inappropriate for women as both dangerous and morally inappropriate, and that the strength of women should be protected in the interest of the future of the race. Night work was particularly inapt as interfering with the responsibilities of motherhood and domestic responsibilities. In a brief prepared by Louis D. Brandeis, it was asserted that

the state was justified in resolving any conflict between women's interest in wage work and society's interest in the domestic and reproductive responsibilities of women in favour of the latter.⁴⁰⁸

Much of the justification for exclusionary policies assumed that women could and did rely on men for economic support. The failure to consider that excluding women from the wage market might have a negative impact on their families, that they might not have families or be capable of reproducing or inclined to reproduce, that there was no evidentiary basis for the assertions on which policies were based, and that women are autonomous individuals well placed to make decisions on their own behalf was not noted. Nor was attention paid to the fact that women were excluded only where their presence was not necessary to the survival of the particular industry. In female-dominated areas, such as hospital work, night work raised none of the concerns that it did in male-dominated areas.

These failures resonate in the current debate about fetal protection policies.⁴⁰⁹ In both the early and the current example of "protectionist" policies, emphasis has focussed on the capacities of women, little attention having been paid to the impact of hazards on male employees. Current policies fail to consider that the alleged evidentiary studies on which fetal protection policies are based reflect the cultural and gender biases of much of science.

The *Johnson Controls* decision is the culmination of several years of critical attention to the problem of hazardous substances in the workplace and, more particularly, to the problem of substances posing an alleged hazard to the reproductive systems of employees. Most often, only female employees were excluded, and restrictions often included all women perceived to be "of reproductive capacity," whether or not those women were pregnant or planning to become so.⁴¹⁰

In the 1970s, as employers came under pressure from the Equal Employment Opportunity Commission to ensure access for women to traditionally male jobs, many companies adopted restrictive fetal protection policies.⁴¹¹ In a notorious case that attracted a great deal of attention, five female employees of American Cyanamid underwent sterilization procedures in order to maintain their access to jobs in the face of exclusionary policies. Several months later, the departments were closed by the corporation, and those jobs were lost.⁴¹² In describing the manner in which the fetal protection policies of American Cyanamid were

formulated, Robert M. Clyne, then the corporate medical director, said that the threshold limit values for fertile females

were arrived at quite arbitrarily and really constitute an educated professional guess rather than anything that we could document on the basis of clinical or laboratory experience.⁴¹³

With regard to fertile men, Dr. Clyne said he was

unwilling to exclude fertile men in the absence of "epidemiological studies indicating that the compound was indeed a human mutagen." He would not be persuaded by animal studies showing evidence of a chemical's mutagenic effect on sperm and claims that "the only meaningful information that [he] would accept is epidemiological information."⁴¹⁴

Dr. Clyne designed a policy that precluded fertile women from access to jobs that involved exposure to 29 chemical substances. This was done with no specific information as to fetal risk with regard to 28 of the 29.⁴¹⁵

Issues of proof of causation are such as to render tort liability highly unlikely.⁴¹⁶ So little is known about the causes of birth anomalies and the multiple factors that influence reproductive outcome that proof that the workplace environment caused *in utero* damage to the fetus is unlikely.⁴¹⁷ Other factors, including smoke, stress on the job, and inadequate rest time, all pose a degree of risk to the fetus that may be higher than the workplace pollutants to which a woman and male co-workers have been exposed. At the same time, stressors outside the workplace and the exposure of the woman's male partner may well be contributing or controlling factors in reproductive injury.

What is known about reproductive health hazards is far outweighed by what is unknown: most commercial chemicals and physical factors have not been thoroughly evaluated for their possible toxic effects on reproduction and development. Much of the information on suspected reproductive health hazards, as with other hazards, is derived from animal studies, which present problems of interpretation in extrapolating to effects in humans.

There are consequently no reliable estimates as yet of the basic measures of reproductive risk in the workplace — the number of workers exposed to such hazards, their levels of exposure, and the toxicity of the agents to which they are exposed.⁴¹⁸

The legal context in which the Supreme Court of the United States reviewed the Johnson Controls policy is primarily defined by the provisions of Title VII of the Civil Rights Act. That act prohibits discrimination in employment on the basis of sex, race, colour, religion, or national origin.⁴¹⁹ The plaintiff must show *prima facie* discrimination, including proof that she belongs to a protected group, applied for and was qualified for the job, and was rejected, and that other candidates were sought.⁴²⁰

Title VII captures two kinds of discriminatory behaviour. The first is "disparate treatment" discrimination, which occurs where the employer

explicitly discriminates against a protected group. Disparate treatment also occurs where the employer excludes a group from employment opportunities, offering an explanation for the difference in treatment that can be shown to be simply a pretext for intentional discrimination. The second form that discrimination may take involves a "disparate impact." Employment practices may appear to be facially neutral but impact more harshly on a particular protected group of employees.

In alleging discrimination, the proof-of-intention requirements vary. In "disparate treatment" cases, the plaintiff must prove intention to discriminate, although intention may be inferred from the differential treatment. In cases of "disparate impact," proof of intention to discriminate is unnecessary, and such cases may be easier to prove.

The two categories of prohibited discrimination also carry different defences. Disparate treatment discrimination may be justified only by an allegation that the distinctions are required as a "*bona fide* occupational qualification." This is a narrow defence, the burden of which rests with the employer. In the context of sex discrimination, this defence has succeeded when used to argue that male sex was a *bona fide* occupational requirement for employment in an all-male correctional institution.⁴²¹ One formulation for the test to determine *bona fide* occupational qualification requires that

the job qualification which the employer invokes to justify his discrimination must be reasonably necessary to the essence of this business ... [the] employer has the burden of proving that he had reasonable cause to believe, that is, a factual basis for believing, that all or substantially all women would be unable to perform safely and efficiently the duties of the job involved.⁴²²

Disparate impact discrimination may be justified only by a judicially created defence of "business necessity." This defence requires the employer to establish that the discriminatory policy is necessary to safe and efficient job performance and that it is not justified with reference to the cost of doing business.

In 1976, the U.S. Supreme Court considered an allegation of disparate impact discrimination under Title VII in a case involving discrimination based on pregnancy and declined to find that discrimination based on pregnancy constituted discrimination on the basis of sex.⁴²³ The court affirmed this approach a year later.⁴²⁴ Congress responded in 1978 by enacting the Pregnancy Discrimination Act specifically to overturn the judgments of the Supreme Court of the United States. The Pregnancy Discrimination Act contains the following clause:

(k) The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes ... as other persons not so affected but similar in their ability or inability to work.⁴²⁵

This amendment to the Civil Rights Act made it clear that Congress viewed discrimination on the basis of reproductive capacity to be overt discrimination involving differential treatment rather than disparate impact discrimination and that the only defence available to the employer would be the *bona fide* occupational qualification defence rather than the judicially created business necessity defence.

In the 15 years leading up to the definitive decision of the U.S. Supreme Court, several key cases assessed fetal protection policies. In the earliest of the major cases, *Wright v. Olin Corp.*,⁴²⁶ the company had established a fetal protection policy whereby its job categories for women were threefold — restricted, controlled, and unrestricted. Jobs in the restricted category were open only to women over the age of 63 or to those women who could prove their sterility. The controlled category required the female employee to sign a form acknowledging some reproductive risk. Male employees were given informal oral information about risk but were not excluded from any job. The report of the reasons for judgment notes that the evidence that the company provided as to the basis for the risk was cursory and limited.⁴²⁷

The case was analyzed as a disparate impact case, the language of the Pregnancy Discrimination Act was ignored, and, on appeal, the court allowed the company to rely on the business necessity defence, which it expanded beyond its earlier definition. In choosing to base its analysis as one of disparate impact, rather than disparate treatment, the court allowed the corporation the broader business necessity defence, rather than limiting the corporation to the *bona fide* occupational qualification defence.

The court suggested the defence was that the safety of third parties, for example customers, could be extended to the "third-party" fetus. The court held that the corporation had to show significant risk of harm to the unborn children of women workers, such that all fertile women need be excluded, but not male employees. The corporation also had to show that the program adopted would effectively avoid the harm and that the evidence of risk was supported in the scientific field, although that support might be qualified.

It suffices to show that within that community there is so considerable a body of opinion that significant risk exists, and that it is substantially confined to women workers, that an informed employer could not responsibly fail to act on the assumption that this opinion might be the accurate one.⁴²⁸

The burden to establish a less discriminatory alternative was left with the employee. Thus, the rules on evidentiary test and burden of proof were relaxed also.

A similarly confused decision was rendered in the *Hayes*⁴²⁹ case. Recognizing the impact of the Pregnancy Discrimination Act, the court in the *Hayes* case held that the policy of firing pregnant X-ray technicians constituted sex discrimination for the purposes of Title VII, was disparate

treatment discrimination, and therefore could be justified only if a *bona fide* occupational qualification could be established. Having so decided, the court then applied the business necessity defence in the expanded form that it had been given by the *Olin* court, in order to "ensure complete fairness to the Hospital."⁴³⁰

In the *Johnson Controls* case, discussed above, the company had established a policy whereby all fertile women were precluded from employment in the battery manufacturing division of the company because of high lead exposure levels. Fertile women were also denied employment in positions that would lead to promotion to those positions and were by necessity blocked from promotion to positions that required experience in the restricted jobs as a prerequisite to promotion. At the first level of appeal, the court failed to give effect to the Pregnancy Discrimination Act, employed the business necessity defence, and analyzed the case as one of disparate impact rather than disparate treatment. This allowed the court to conclude that the employee had failed to discharge her burden of proof with regard to establishing that a less discriminatory scheme would equally accomplish the corporation's goals. In addition, the appeal court held that even under a *bona fide* occupational qualification test, the company's exclusionary policy would survive, that there was an overlap between the *bona fide* occupational qualification test and the business necessity test, and that the business necessity test could encompass cost-of-doing business considerations.

The American Equal Employment Opportunity Commission (EEOC) responded to this decision by issuing a policy guideline⁴³¹ suggesting that the Court of Appeal had wrongly decided the case, that fetal protection policies must be analyzed as disparate treatment cases, and that the employer bore the burden of the *bona fide* occupational qualification defence. This defence, in the EEOC's opinion, is a narrow one, requiring that the employer establish that the discriminatory policy is "necessary to the normal operation of the particular business." The EEOC suggested that the employer must show that it takes reasonable steps to identify and shield all persons from the specific hazard, that it takes similar steps to protect the offspring of both male and female employees, and that less restrictive and discriminatory alternatives are not available.

Following the decision in the Court of Appeal and the guideline published by the EEOC, Senator Kennedy and 37 co-sponsors introduced the Civil Rights Act of 1990, which would have amended the Civil Rights Act of 1964.⁴³² The act, vetoed by President Bush, would have effectively overturned certain aspects of the *Olin*, *Hayes*, and *Johnson Controls* cases. The amending provisions would have required that the business necessity defence be used only in disparate impact cases,⁴³³ that the proof of business necessity rests on the employer,⁴³⁴ and that the definition of business necessity is "essential to effective job performance."⁴³⁵

Because of the poor record of the Supreme Court of the United States in previous pregnancy discrimination cases and the perceived sense that

the court was narrowing the parameters of the Civil Rights Act in other contexts as well, there was a great deal of concern that the court would fail to strike down the fetal protection policies in *Johnson Controls*. This concern proved misplaced.

United Auto Workers v. Johnson Controls held that the corporation's fetal protection policy constituted sex discrimination within the purview of the Civil Rights Act of 1964 as amended by the Pregnancy Discrimination Act. The court further held that the case should be analyzed as a differential treatment case and that the only defence available was a *bona fide* occupational qualification defence. The court squarely faced the question as to whether or not the employer could discriminate against fertile female employees because of its health concerns for any fetuses the women might conceive.

Prior to the enactment of the Civil Rights Act of 1964, Johnson Controls had employed no women in its battery manufacturing plant. In 1977, Johnson Controls implemented its first fetal protection policy, which allowed women access to jobs that entailed exposure to lead and informed women of the risks associated with lead exposure. In 1982, Johnson Controls moved to a policy of exclusion of women of childbearing capacity. In 1984, this policy was challenged as sex discrimination by three plaintiffs and their unions. The first plaintiff was a woman who had chosen sterilization in order to keep her job, the second woman had suffered a reduction in the level of compensation she received when she was transferred out of a job that involved exposure to lead, and the third was a male plaintiff who had been denied a transfer for the purpose of lowering his lead level as he intended to become a father.

Justice Blackmun, writing for the majority, held that the policy constituted discrimination on the basis of sex, within the terms of the Civil Rights Act, as amended by the Pregnancy Discrimination Act. He held that the discrimination was within the category of "disparate treatment" or "facial" discrimination (discrimination on the "face of" or text of the legislation). The majority make it clear that any analysis of the policy that suggests that disparate impact analysis is appropriate is mistaken; the appropriate analysis is differential treatment, not disparate impact. In light of the evidence that lead has a debilitating effect on male reproductive capacity, a policy that requires only female employees to produce proof of sterility is clearly discriminatory. The court added that a policy that discriminates on the basis of reproductive capacity is one that discriminates on the basis of pregnancy and should be treated as sex discrimination. The absence of a "malevolent motive" did not take the disparate treatment discrimination and convert it to disparate impact discrimination, nor do benign motives allow a defence of business necessity to be substituted for one of *bona fide* occupational qualification.⁴³⁶

The court then proceeded to measure the corporation's policy against the *bona fide* occupational qualification defence. Pointing out that the policy was a narrow one, Justice Blackmun stated that the test is met only

in "certain instances" where sex discrimination is a "reasonable necessity" to the "normal operation" of the "particular" business. He added:

Each one of these terms — certain, normal, particular — prevents the use of general subjective standards and favors an objective, verifiable requirement. But the most telling term is "occupational"; this indicates that these objective, verifiable requirements must concern job-related skills and aptitudes.⁴³⁷

The qualifications to which the defence refers are those that affect an employee's ability to do the job. Women who are pregnant or who may become so must be treated like other employees. "Women as capable of doing their jobs as their male counterparts may not be forced to choose between having a child and having a job." The majority found that third parties contemplated by the *bona fide* occupational qualification test did not include the fetus and that the decision about whether to work while capable of becoming pregnant was the woman's.

Decisions about the welfare of future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents.⁴³⁸

The majority also noted the paucity of the evidentiary record on which Johnson Controls based its concerns. During the time that women were employed in the battery-making operation, there were eight pregnancies reported, with no record of abnormalities or birth defects. The rate of pregnancy nationally for female workers is 9 percent. After the age of 30, the birth rate drops to 2 percent.

The court also specifically suggests that corporate concern over tort liability to future offspring is misplaced as a justification for excluding women from its workplace. The court notes that Johnson Controls is in compliance with the Occupational Safety and Health Administration's (OSHA) gender-blind lead exposure standard. OSHA had specifically declined to recommend the exclusion of women of childbearing capacity from the workplace. As this would be evidence that the company had acted in a responsible and non-negligent manner, tort liability is "remote at best."⁴³⁹ The court also reminds us that the issue of a tort award of damages "reflects a fear that hiring fertile women will cost more." The extra cost of hiring women is not a defence to an action alleging violation of Title VII.

The majority opinion concludes that "concern for a woman's existing or potential offspring historically has been the excuse for denying women equal employment opportunities."⁴⁴⁰

The decision of the Supreme Court in the *Johnson Controls* case was a welcome one. We may only review with amazement the tortuous route through the courts that fetal protection policies have followed, noting the extent to which the legal obligations imposed by Title VII were distorted continuously by those courts (including the Supreme Court) that were asked to deal with discrimination on the basis of reproductive capacity and fetal protection policies.

Fetal protection policies do clearly echo the earlier response to women in the male workplace. The impulse is to ignore the ability of the woman herself to determine whether the work she is undertaking involves a level of risk that she feels is appropriate to her, in all of her circumstances.⁴⁴¹ Women are perceived as reproductive entities only, and all are assumed to be continuously fertile, unable to control their fertility, engaged in heterosexual sexual activity, and primarily reproductive beings. Furthermore, the role of male reproductive capacity, and of workplace and other risks to that capacity, is ignored. The degree to which male reproductive health is important to the future of children is overlooked. This risk includes the clear possibility that the male worker carries toxic substances home on his clothing and skin from his own workplace. The blindness toward the male's reproductive health is a reflection of the prevailing cultural assumption that any injury or deviation in a child is the responsibility of the partner who carried that child in her womb. The evidence available on risks to fertility and successful pregnancy outcome is selectively reviewed, is assumed to be definitive when it clearly is not, and is equally assumed to be value free. Where there are costs to be assumed in ensuring the positive outcome of reproductive activity, those costs are imposed on the women themselves rather than assumed by the employer, all workers, and the general public. The decision of the Supreme Court of the United States in *Johnson Controls* is a welcome reversal to the long list of impediments imposed on women's access to fair and equitable employment.

Actions in Tort

A limited number of earlier cases have suggested that liability for tort may be available for actions by pregnant women alleged to have caused injury *in utero* to their children subsequently born alive. Traditional tort doctrine allows for recovery where the wrongdoer owes a duty of care not to act in a manner that will cause injury to a third party, does so in a negligent or intentional fashion, and causes injuries that may be compensated for within those categories that the common law recognizes. Interestingly, the common law has been extremely reluctant to compensate the injuries of children and parents where the issue is "wrongful birth" or "wrongful life," arguing that to be born alive in any state is preferable to not having been born at all, in cases where the negligence is that of a health care professional. In other cases, the law is now clear that where a duty of care is owed by a third party, as in automobile negligence, and an injury is done to the fetus *in utero*, recovery for those injuries will be allowed so long as the fetus is subsequently born alive.⁴⁴²

Tort actions against women by children are of concern because they assume a "duty of care" to the fetus, which, when the child is subsequently born alive, gives rise to a cause of action for compensation. This cause assumes a duty of care owed by the pregnant woman to the fetus that she carries, suggesting that her conduct toward the fetus must be qualified and allowing for the possibility that a series of various duties owed by the

pregnant woman to her fetus will be developed. On a list of such obligations, various authors have argued one may find liability for diet, use of prescription and non-prescription legal drugs, smoking, alcohol use, exposure to infectious disease, workplace hazards, exercise, sexual intercourse, and other potential causes of harm.⁴⁴³

In fact, there have been only a very few instances of tort liability imposed on mothers for actions determined to be a breach of duty owed to the fetus that have ripened into an actionable wrong upon the live birth of the fetus. In *Grondin v. Grondin*,⁴⁴⁴ the court suggested that recovery by a child against his mother would be allowed where medication taken by the mother during pregnancy resulted in permanent discoloration to the child's teeth. The facts are of interest. Ms. Grondin had been informed by her physician that it was "impossible for her to become pregnant." Only after consulting a different doctor was she told that she was seven or eight months pregnant. Meanwhile she had been taking the medication. The original action by the child against the physician for negligence and malpractice was amended so as to allow the child to complain of negligence on the part of his mother "in her failure to seek proper prenatal care, for failure to request that [the doctor] perform a pregnancy test," and her failure to inform the doctor that she was on medication:

A woman's decision to continue taking drugs during pregnancy is an exercise of her discretion. The focal question is whether the decision reached by a woman in a particular case was a "reasonable exercise of parental discretion."⁴⁴⁵

The court remanded for a determination of whether or not the exercise of parental discretion in taking medication could be characterized as "reasonable."

More recently, in *Stallman v. Youngquist*,⁴⁴⁶ an action by the child against her mother for injuries suffered *in utero* during an automobile accident was held to disclose no cause of action. In the *Stallman* case, the court reviewed the development of the law to the point at which injury suffered *in utero* at the hands of a third party was actionable provided the child was subsequently born alive. In language highly critical of the *Grondin* decision, the court states:

The *Grondin* court would have the law treat a pregnant woman as a stranger to her developing fetus for purposes of tort liability. The *Grondin* court failed to address any of the profound implications which would result from such a legal fiction and is, for that reason, unpersuasive.⁴⁴⁷

The court continues:

It is clear that the recognition of a legal right to begin life with a sound mind and body on the part of a fetus which is assertable after birth against its mother would have serious ramifications for all women and their families, and for the way in which society views women and women's reproductive abilities. The recognition of such a right by a fetus would necessitate the recognition of a legal duty on the part of the

woman who is the mother; a legal duty, as opposed to a moral duty, to effectuate the best prenatal environment possible. The recognition of such a legal duty would create a new tort: a cause of action assertable by a fetus, subsequently born alive, against its mother for the unintentional infliction of prenatal injuries.⁴⁴⁸

The court adds that while subjecting a third party to liability for injuries to a fetus subsequently born viable furthers the interests of both mother and child and does not subject the defendant to control of his or her life, scrutiny of a pregnant woman's decisions would subject the woman to state scrutiny of all decisions and violate her right to autonomy and to privacy.

This strong judicial rebuttal, on the basis of policy, of a tort action for maternal prenatal negligence suggests that this is an unlikely avenue for future judicial interference with gestation and birth.⁴⁴⁹ Combined with the comments of the Supreme Court of the United States in *Johnson Controls* to the effect that tort liability need not be a serious concern and ought not to be used as an excuse for discriminatory actions, concern about tort liability ought not to be used as an excuse to preclude women from access to non-traditional jobs.

Conclusions and Recommendations

This report has reviewed the various forms of legal interference into gestation and birth. They are many.

The history of the criminal law's control of women's reproductive capacity has been reviewed, and the extent of that regulation and its historical endurance have both been noted. The various mechanisms that courts have used to control reproductive behaviour, including the use of mental health legislation, sentencing provisions, legislative schemes, and various theories allowing for imposed treatment, have been detailed. Where the reasoning in the cases is erroneous in law, as has often been true, the errors have been noted. The use of differential standards that have resulted in the exclusion of women from the traditionally male workplace has also been examined.

While this report has examined a broad range of forms of interference with gestation and birth, others have not been reviewed. Among these can be included regulation of contract motherhood, the denial of access by women to alternative birthing experiences including midwifery, and the continuing concerns about access to therapeutic abortion services both in the United States and in Canada. In the United States, we might also include the absence of any meaningful provision of pregnancy or maternity leave benefits. In that country, we might well also focus on the absence of health care for women and for their children. In Canada, concerns must be raised about the differential level of health care services provided to

women in isolated geographic locations, and particularly to First Nations women and children. In general, we might argue that the level of interference and regulation is high, but the level of support and services less apparent.

It is clear that the level of interference with gestation and birth that occurs in the United States is significantly greater than that which occurs in Canada. Ought this to cause us to conclude that the problem is an American one and need not be a subject of serious concern for Canadians or for the Commission? I think not.

Granted, the level of activity in the United States is several times greater than that in Canada. This is a function of several factors, including the comparative size of the two populations. But in each and every case, the issues raised in the United States with a high level of activity are exactly those raised in Canada on a smaller scale. Workplace policies, addiction issues, sentencing parameters, and the substitution of the health care decisions of a third party for those of the pregnant woman all have occurred in Canada. Actual and proposed legislative interference with gestation and birth has occurred here as well. Professional health care organizations, legislatures, and law reform bodies have considered proposals for and against interference with reproduction and gestation. In my view, Canadians in general, and the Commission in particular, face exactly the same issues of policy that our American counterparts face.

Where legislative initiatives have occurred, the constitutionality of those initiatives is seriously questionable. To date, in the limited number of cases considering the constitutionality of legislative preference for the fetus, no court in Canada or in the United States has upheld any such statutory preference. Policies that prefer the fetus, such as workplace exclusion policies, have been held to violate anti-discrimination provisions and human rights codes. Where the litigation is based on common law, the conclusion at the appeal level has been the same. Preference to the fetus has not been maintained.

In both Canada and the United States, the women who are the subject of interference with gestation and birth are those who are subject to state scrutiny because of their economic vulnerability and previous engagement with the state in order to obtain needed services.⁴⁵⁰ In the United States, clear evidence is available that racism operates in the selection of women who are made the subject of surveillance and scrutiny. There is also clear evidence of cultural insensitivity by members of the dominant culture to the health care needs of other communities.

Activity of a similar kind in Canada probably reflects similar insensitivities. The limited information available suggests that this is the case. All of the women represented in the Canadian cases concerning interference with maternal decision making were previously involved with state social services. At least two were members of a racial minority. An extensive literature is now available to document the racist nature of the Canadian state's involvement through the criminal justice system with First

Nations communities. Similar serious concerns have been raised by other minority communities. Child welfare authorities have been subject to similar criticism both by members of the First Nations and by persons of colour.⁴⁵¹

First Nations women and infants have a health status that falls well below that of the general Canadian population. Their need is for basic reproductive health care, not for coercive measures. Comparative infant mortality figures reveal an infant mortality rate among registered members of the First Nations more than double the rate for the non-Indian population.⁴⁵² The health status of First Nations women and their reproductive health care needs differ from those of the general Canadian population. First Nations women are younger, entering their childbearing years, while women in the general population are in an aging population group.⁴⁵³ First Nations women have a fertility rate that is higher than that of the non-Native population. They live in housing conditions that are substandard in comparison with those of the general Canadian population, with a corresponding impact on maternal and infant health indicators.⁴⁵⁴ Their average annual incomes are lower than those of the general population.

There is a proven linkage between income levels and health status.⁴⁵⁵ Thus, pregnant Native women living both on and off reserves are considered to be members of a high-risk community. In addition, their health care needs reflect different cultural expectations and needs.⁴⁵⁶ Native communities have generally perceived that the health care services with which they are provided by the various levels of government reflect a conflicting definition of what constitutes "health," reflect government denial of entitlement to services at all levels of government/First Nations interaction, and reflect a policy of assimilation and an attempt to reduce funding.⁴⁵⁷

Reproductive health care services for First Nations women and their children must reflect a culturally appropriate response to a First Nations concept of health.⁴⁵⁸ Certainly the *J.M.* case⁴⁵⁹ reflects a clear policy of assimilation.

An additional concern, not noted in either the cases or the critical literature,⁴⁶⁰ is the degree to which the women represented in the cases appear to be living in relationships that are subject to male violence. In several of the Canadian judgments, reference is made to the violence of the male partner, but never in any way that shows understanding of the impact of violence on the woman's ability to engage successfully with health care or social services within the community. In cases that impose health care on a woman or deny her custody of her child, where the violence of her partner is commented on, no reference is made to the impact of that violence on her ability to obtain requisite services or to care successfully for her children. No reference is made to the responsibility of the male partner. This is most disturbingly represented by two U.S. cases. The first is that of Pamela Rae Stewart, charged on the basis, in part, that she engaged in

sexual intercourse with her husband. The husband was not charged. The second case that best reflects the willingness to blame the mothers and to interfere with their lives while ignoring the context involved an abused woman who, when attending at a hospital emergency ward because of physical abuse, was charged with fetal abuse because of her blood alcohol level. In Canada, the *McDonald and Ackerman v. McGoldrick* cases in British Columbia and the *Re A.* case in Ontario are equally troubling.

Particularly in the United States, when children are removed from their mothers, this is done in the context of a child welfare system notorious for its failures and its inadequate resources.⁴⁶¹ Concern about fetal welfare may reasonably be described as bizarre in a jurisdiction that makes only the most limited provision for prenatal care, for post-natal and infant care, and for the provision of housing and nutrition for children after their birth.

Another common thread that causes concern is the degree to which the various social policies designed by legislators or created through judicial fiat are found to be seriously wanting whenever their allegedly empirical bases are examined. The science on which workplace exclusion policies have ostensibly been based becomes, on closer examination, personal, inaccurate, and paternalistic hypothesis. Imposed medical treatment, in addition to flying in the face of legal precedent, is generally considered inappropriate by organized medicine and is often based on erroneous medical prediction. Preventive sentencing does not preclude access to drugs, reduces the opportunities for adequate prenatal health care, and leaves a woman's other family obligations, including children, unattended. The imposition of contraception never mentions the serious health risks, known and not yet known, associated with those drugs.⁴⁶²

Each of the various forms of interference with gestation and birth evidences a willingness to place both the responsibility and the burden of gestation on women, rather than to see the responsibility as one to be shared by all members of society.⁴⁶³ Requiring women alone to bear the burden of the costs of gestation is contrary to general legal principles of non-discrimination. Requiring women who have limited independent resources to subject themselves to the allegedly appropriate and benevolent decisions of the state further victimizes women who are already victimized by their precarious financial circumstances and by our cultural and racial intolerance.⁴⁶⁴ Protests that these mechanisms are used to secure the health of the fetus ring hollow in the face of the limited resources available for the support of women and their living children and the additional limitations on support for women and children that arise where marital status is deemed to be relevant.

However critical we may be of the response of legislators and of the judiciary to concerns about women's health status during pregnancy, there are several important problems that need to be addressed. Issues of inadequate prenatal health care, environmental and workplace hazards, and the impact of addictions on maternal and fetal health are appropriate

areas of concern. What are the appropriate responses? What is the impact of imposing criminal sanctions on women who use alcohol or drugs occasionally or who have addiction problems? What is the impact of applications to the courts to second-guess the health care decisions made by the pregnant women themselves? What are the alternatives to excluding women of reproductive capacity from hazardous workplaces?

Are coercive measures of whatever kind an appropriate response to drug and alcohol use issues?⁴⁶⁵ The recent literature on addictions clearly concludes that coercive measures are seriously inadequate and are counterproductive. The Board of Trustees of the American Medical Association recommends that "pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs."⁴⁶⁶ Similar conclusions have been reached by others studying the problem of maternal drug use, among them the Center for the Future of Children, which, in a study dealing with drug-exposed infants, recommended the following:

A woman who uses illegal drugs during pregnancy should not be subject to special criminal prosecution on the basis of allegations that her illegal drug use harms the fetus. Nor should states adopt special civil commitment provisions for pregnant women who use drugs.⁴⁶⁷

A recent study by the Motherisk Program at the Hospital for Sick Children in Toronto concluded that pregnant women who are drug users can avoid injury to their infants if they are able to stop using the drug in the first three months of the pregnancy.⁴⁶⁸ There is little evidence that prenatal substance exposure, including exposure to tobacco, cocaine, marijuana, or alcohol, results in significant deficits when measured on standardized tests. Rather, low socioeconomic status directly correlates with performance deficits. Post-natal environments are crucial.⁴⁶⁹ These studies suggest that the circumstances and abilities of mothers to parent under situations of economic marginality and personal histories of abuse and deprivation often make the prospects for successful parenting of substance-exposed infants difficult.⁴⁷⁰ These challenges are best met not by incarceration and punitive measures but by economic and other support services provided in a meaningful manner.

Child maltreatment is associated with alcohol and drug abuse, and also with poverty, family and community dysfunction, and homelessness. Child maltreatment is also associated with society's lack of commitment to prevention and early intervention services for families at risk of abusive behavior. Hardest hit by the drug epidemic have been disadvantaged communities and families who were previously coping, if only marginally.⁴⁷¹

Parenting skill programs have been reported to improve successfully the skills of drug-abusing parents and to decrease behavioural and emotional difficulties in their children. These programs have been reported to be successfully translated to work with black, addicted mothers. Other

culturally sensitive versions are in the process of development.⁴⁷² The absence of reference to the parenting skills, contributions, and responsibilities of male partners should be noted; this lack is not sufficiently justified by the incidence of absence of male partners in the home. Rather, the literature evidences the culturally prevalent assumption that responsibility for the health status and behaviour of children rests solely with their mothers.⁴⁷³

Resources for drug treatment in the United States are minimal when compared to those available for drug policy enforcement.⁴⁷⁴ In the proposed U.S. federal budget for 1992, 70 percent of all resources are allocated to supply reduction programs. Only 30 percent are allocated to demand reduction programs in the form of education and of treatment. A minimal number of these programs are designed specifically to apply to women; even fewer accept pregnant women.⁴⁷⁵ Of the pregnant women reported in treatment in the United States, 82 percent were white women.⁴⁷⁶ In Canada, the statistics are better. Twenty percent of all resources are directed to enforcement and control. Thirty-eight percent are directed to treatment and rehabilitation. Thirty-two percent are directed to education and prevention.⁴⁷⁷ Under the Community Action Program, sponsored by the federal government, several programs specific to the needs of women and to persons in correctional institutions have been funded.⁴⁷⁸

Historically, health care services for women have been underfunded.⁴⁷⁹ In Canada, by contrast, programs are in short supply, but they accept pregnant women and attempt to give them preferential treatment. The Motherisk Program at the Hospital for Sick Children in Toronto is specifically designed for pregnant women.⁴⁸⁰

The report of the Inter-American Commission on Drug Policy⁴⁸¹ recommends that the Americas launch a cooperative program to reduce consumer demand rather than dedicate resources to supply reduction. This recommended program would include drug treatment in all penal systems, the targeting of drug-using women of childbearing age for counselling and for treatment, publicly funded programs for youth, and drug treatment for all who need it.⁴⁸² This report notes that the "war on drugs" has engaged in deeply disturbing behaviour.

One of the most cynical mechanisms has been the scapegoating of minorities and "foreigners." Another has been to declare victory when drug abuse recedes among the middle class, even when drug abuse and traffic continue to plague the dispossessed — including abandoned and neglected children, the homeless and female heads of households in inner cities.⁴⁸³

These programs must specifically fund treatment for disadvantaged groups and must respond to the cultural sensitivities of the varied user populations. Drug treatment must be effectively tailored to the needs of specific groups, "including women and children."⁴⁸⁴ The report also concludes that there is no evidence that incarceration alone decreases drug

use or criminal behaviour by drug users.⁴⁸⁵ Rather, fear of criminal prosecution and loss of custody are barriers to women's participation in substance abuse programs.⁴⁸⁶

Nor are differential workplace exposure standards an appropriate response to the hazardous workplace. It is far from clear that there exists an evidentiary basis for excluding women of reproductive capacity from the workplace. Recent research suggests that the impact of reproductive hazards on the male partner is as profound as any on the female partner. Nor can women be expected to carry the burden of the social and financial costs of reproduction. Differential standards violate women's entitlement to non-discriminatory treatment in the workplace. Standards that protect the reproductive capacity of both sexes are clearly possible and are used in many Canadian jurisdictions. Quebec's protective reassignment provisions for pregnant and lactating workers are a creative and enhancing approach to the issue of workplace hazards and ought to be considered for duplication by the federal and by provincial governments, with possible expansion to correct the limitations of the legislation described in the body of this paper.

In short, juridical intervention in gestation and birth reflects the patriarchal nature of North American society. Legislative and judicial responses to social problems have proven to be counterproductive. The Commission should give clear direction in its report to the government, to legislatures, and to courts that the appropriate response to pregnancy and childbirth is to offer easy access to culturally appropriate support services for women and children, designed by women to meet the broad needs of women and children. Not only are punitive or coercive measures counterproductive and a violation of women's legal rights, but they suggest a patriarchal response designed to reinforce gender roles, rather than a legitimate attempt to meet the broad needs of women and to foster the birth of healthy children.

Appendix 1

Scope of the Appendix

Issues of maternity leave and allowances did not fall within the ambit of this report, as they are essentially concerned with support after birth. However, it is worthwhile noting that in most countries that have provisions for maternity leave, a certain number of days or weeks must be taken before the birth. Similarly, many countries that pay maternity benefits will pay the same benefit if some of the leave is taken before confinement.⁴⁸⁷

Australia

Status of the Fetus

A fetus has no right of its own until it is born and has a separate existence from its mother.⁴⁸⁸

A fetus has no legal personality or rights of its own until born and therefore has no common-law right to prevent termination of the pregnancy.⁴⁸⁹

The word "child" in the Family Law Act, s. 70 c(1), does not include an unborn child.⁴⁹⁰

Austria

Employment During Pregnancy

It is forbidden to employ women during pregnancy and the 12 weeks following confinement in physically arduous work; in jobs exposing them to the effects of harmful substances or radiation, dusts, gases or vapours, heat, cold and humidity, vibrations, or noise; or in assembly-line piecework. In addition, the employer has to organize the work and equip the premises, taking into account the necessary precautions and protective measures.⁴⁹¹

Pregnant workers have the right to be transferred to another post and work compatible with their condition, without loss of wages. Pregnant women also have the right to transfer for individual reasons. As a rule, all that is needed for such a transfer is a medical certificate saying that it is necessary. If such transfer is impossible, the woman is guaranteed continued payment of wages by the employer.⁴⁹²

Night work is specifically forbidden for pregnant women and nursing mothers.⁴⁹³ However, there are many exceptions to the basic prohibition.⁴⁹⁴

Overtime work for pregnant women and nursing mothers is prohibited.⁴⁹⁵

Belgium

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁴⁹⁶

Employment During Pregnancy

It is prohibited to employ pregnant women in work exposing them to the harmful effects of mechanical vibrations or high temperatures; any carrying of loads by hand is prohibited during the last three months of pregnancy and the ninth and tenth weeks following it. Pregnant women may not be employed in jobs exposing them to the harmful effects of chemical products or those entailing a risk of viral infection.⁴⁹⁷

Women workers have the right to be transferred to another post and work compatible with their condition, without loss of wages. Pregnant

women also have the right to transfer for individual reasons. As a rule, all that is needed for such a transfer is a medical certificate saying that it is necessary. If such transfer is impossible, the woman has to apply for sickness insurance benefits, which amount to 60 percent of her previous wages.⁴⁹⁸

Overtime work for pregnant women and nursing mothers is prohibited.⁴⁹⁹

Bulgaria

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁵⁰⁰

China

Employment During Pregnancy

Prior to 1988, labour regulations did not discriminate between women and men with respect to the work assigned to them. In 1988, Changzhou province adopted regulations prohibiting the assignment of women to underground work, to work in refrigerated plants, or to work involving heavy vibration. Heavy manual work is also prohibited. Pregnant women are no longer to be exposed to harmful substances such as benzene, mercury, lead, cadmium, carbon disulphide, or any form of radiation in doses that exceed strictly limited minimums.⁵⁰¹

Columbia

Employment During Pregnancy

A woman worker may not be dismissed on grounds of pregnancy and motherhood at any time during pregnancy and for three months after giving birth. However, in order to benefit from this protection, the onus is on the worker to tell the employer that she is pregnant.⁵⁰²

Czechoslovakia

Constitutional Principles

The 1960 Constitution of the Czechoslovak Socialist Republic states as a basic principle of equality:

The equal status of women in the family, at work, and in public life shall be secured by special adjustment of working conditions and special health care during pregnancy and maternity, as well as by the development of facilities and services which will enable women to fully participate in the life of society.⁵⁰³

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁵⁰⁴

Employment During Pregnancy

The Czech labour code prohibits giving women work that is physically unsuited or is detrimental to them, especially work endangering their mission as mothers.⁵⁰⁵

All women are forbidden to manually lift weights greater than 15 kg, but this restriction is widely ignored.⁵⁰⁶

Pregnant workers may remain in the same unhealthy or dangerous job if the working conditions are improved through elimination of the adverse factors. This may be achieved by lowering production targets, reducing machine speed, permitting additional breaks, etc. If, as a result of these changes, the woman's wages are reduced, a special compensatory supplement must be paid to bring the wages back up to the previous level.⁵⁰⁷

Denmark

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁵⁰⁸

Employment During Pregnancy

Current legislation in Denmark is marked by an almost total absence of special protection for women.⁵⁰⁹

England

Status of the Fetus

The fetus has no right of its own, at least until it is born and has a separate existence from the mother. A husband has no right in law or equity to stop his wife from having an abortion.⁵¹⁰

When a fetus has been injured due to the negligence of a person *other than the mother*, and the fetus is subsequently born alive, the child can maintain a cause of action only if there was a duty owed to one or the other of the parents. Thus, liability to the live-born child is derivative.⁵¹¹

A pregnant woman driving a motor vehicle has a duty of care to the fetus, and, if her fetus is injured as a result of a breach of that duty, the subsequently born child has a cause of action against her.⁵¹²

A claim for "wrongful life" is contrary to public policy and cannot sustain a cause of action.⁵¹³

"Care proceedings" under the Children and Young Persons Act 1969 can be brought only in respect of a child who has been born. However, the courts are entitled to look at how a mother behaved toward her unborn

child for the purposes of determining whether the child once born should be placed in care.⁵¹⁴

The courts have no jurisdiction to make an unborn child a ward of the court.⁵¹⁵

Medical Care During Pregnancy

Time off with pay for care and medical visits during pregnancy has been legislated.⁵¹⁶

Employment During Pregnancy

Where an employer refuses to permit a woman to perform certain jobs for reasons of safety, such a refusal does constitute discrimination based on sex. However, if the refusal was required in order for the employer to comply with another statute (requiring that a safe workplace be provided for all employees), the employer's actions are protected.⁵¹⁷

There is no principle of law preventing application of the Sex Discrimination Act 1975 to cases where a woman claims to be discriminated against on the basis of pregnancy. The correct test is whether the pregnant woman has been treated less favourably than a man in comparable circumstances.⁵¹⁸

It is unfair to dismiss an employee if the principal reason for her dismissal is that she is pregnant or for any other reason connected with her pregnancy, unless she is incapable of adequately doing her work because of her pregnancy or she cannot continue to do her work without contravention of any other enactment.⁵¹⁹ This provision has been interpreted to mean that she is unfairly dismissed if she is released for incapacity in doing her work because of pregnancy-related illness,⁵²⁰ if she is selected for redundancy on the basis that she will require maternity leave,⁵²¹ or if she is dismissed during her maternity leave for reasons that the employer cannot find a temporary replacement.⁵²² The employer must provide alternative employment or demonstrate that no suitable alternative exists.

Examples of modern legislation making special reference to pregnancy include the Air Navigation Orders, S.I. 1985 No. 1643; the Control of Lead at Work Regulations 1980, S.I. 1980 No. 1248; the Merchant Shipping (Medical Examination) Regulations 1983, S.I. 1983 No. 808; and the Ionising Radiations (Unsealed Radioactive Substances) Regulations 1985, S.I. 1985 No. 1333. This latter limits a pregnant employee's exposure to X-rays, gamma rays, and neutrons. Restrictions on women working in mines or quarries and cleaning machines in factories were repealed in 1989.⁵²³ An industrial tribunal has ruled that a pregnant woman's request to be transferred from a position requiring operation of a visual display unit (VDU) during pregnancy, based on her own genuine health fears, merits serious consideration and may not be rejected out of hand.⁵²⁴

Finland

Employment During Pregnancy

Current legislation in Finland is marked by an almost total absence of protective legislation for women. However, Finland has ratified the International Labour Organization (ILO) Conventions prohibiting underground work by women (No. 45); the White Lead (Painting) Convention (No. 13); and the Benzene Convention (No. 136).⁵²⁵

France

Status of the Embryo/Fetus

A fetus of less than 10 weeks is not protected by law.⁵²⁶

Prenatal Allowances

Every pregnant woman shall receive a prenatal allowance from the day that she declares her pregnancy. The right to a prenatal allowance is conditional on the woman observing the requirements of the Public Health Code (see below). A portion of the allowance is payable after each examination.⁵²⁷

Medical Care During Pregnancy

In order to receive any state allowances, every pregnant woman must report her pregnancy to the social services organizations and follow the advice of a "social assistant" concerning hygiene and preventive medicine. Furthermore, she must have at least three medical examinations during the pregnancy, details of which are dictated by the Minister of Public Health and Population on advice from the National Academy of Medicine, and one post-natal examination in the eight weeks following delivery.⁵²⁸

The Minister may, by order, determine in what conditions a fourth medical examination during the pregnancy will be required.⁵²⁹

Social assistants will visit pregnant women whose financial or moral situation requires special protection in their homes.⁵³⁰

The costs of medical care related to pregnancy and to delivery are borne by the social security system throughout the entire nine months, including the free issue of pharmaceutical and other relevant supplies. Medical costs not associated with pregnancy are covered only in the last four months of the pregnancy.⁵³¹

Work During Pregnancy

It is forbidden to refuse to hire a woman because she is pregnant.⁵³²

It is absolutely forbidden to release any woman from employment during the course of her maternity leave. During the whole of the pregnancy, a woman may be released only for grave cause unrelated to her pregnancy, or because of the impossibility of continuing the contract.⁵³³

It is absolutely forbidden to employ any pregnant woman during the last two weeks of her pregnancy and the six after delivery.⁵³⁴

If the health of the pregnant worker does not require it, an employer may not transfer her to another position. However, if her health requires it, the woman may request such a transfer, or her employer may suggest it if the employer has medical advice affirming the necessity for changing jobs. If the employer suggests the transfer, the employee's salary must be guaranteed at the pre-transfer level. If the employee herself requests the transfer, her salary is not guaranteed unless she had at least one year's seniority at the beginning of the pregnancy.⁵³⁵ If no transfer is possible, the woman has to apply for sickness insurance, which is paid at 50 percent of her former wage.⁵³⁶

It is forbidden to employ pregnant women at out-of-doors stalls if the temperature is below 0°C, or after 10 p.m.⁵³⁷

Pregnant women may not be required to transport items by specified vehicles (such as bicycle, porter's dolly).⁵³⁸

Pregnant women have the right to private medical supervision by the workplace physician.⁵³⁹

Certain other measures are not specifically aimed at pregnant women. These include

- a ban on employment of women in underground mines and quarries;
- maximum limits on weights, according to sex;
- obligation on employers to provide a number of seats in the workplace equal to the number of women employed there;
- the ban on the use of certain means of transport by women, where a doctor deems it necessary.⁵⁴⁰

This year, a ban that had been in place for nearly four decades on women working in industrial jobs at night was lifted. The European Court of Justice ruled the ban conflicted with the principle of equal rights for both sexes. In 1991, women represented only 28 000 of the nearly one million nighttime industrial workers. These women obtained exemptions from the ban.

Germany

The source materials reflect the legislation of the German Democratic Republic (East Germany) and the Federal Republic of Germany (West Germany). No information was available as to the post-unification situation. Each reference therefore is annotated as East or West.

Status of the Fetus

The West German Federal Constitutional Court has ruled that the constitutional protections in Article 2, Section 2 of the Basic Law, which provides: "Everyone shall have the right to life and to inviolability of his person," apply to life growing inside the womb.⁵⁴¹

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme (both East and West). In the West, this includes the free issue of pharmaceutical and other relevant supplies.⁵⁴²

Employment During Pregnancy

It is forbidden to employ pregnant women and nursing mothers at physically arduous work; in jobs exposing them to the effects of harmful substances or radiation, dusts, gases or vapours, heat, cold and humidity, vibrations, or noise; or for assembly-line piecework. In addition, the employer has to organize the work and equip the premises, taking into account the necessary precautions and protective measures (West).⁵⁴³

Pregnant workers have the right to be transferred to another post and work compatible with their condition, without loss of wages. Pregnant women also have the right to transfer for individual reasons. As a rule, all that is needed for such a transfer is a medical certificate saying that it is necessary. When such transfer is not possible, the woman is guaranteed continued payment of her wages by the employer (West).⁵⁴⁴

Night work is specifically forbidden for pregnant women and nursing mothers (West).⁵⁴⁵

Overtime work for pregnant women and nursing mothers is prohibited. Time off with pay for care and medical visits during pregnancy has been legislated (West).⁵⁴⁶

A medical practitioner may exclude an expectant mother from employment upon finding that "her life or health or the health of her child would be endangered by her continuing the employment."⁵⁴⁷

Hungary

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme. This includes the free issue of pharmaceutical and other relevant supplies.⁵⁴⁸

Work During Pregnancy

From the beginning of the fourth month of pregnancy, until her child reaches the age of one year, a female employee cannot be required to perform night work.⁵⁴⁹

There are certain occupations and jobs that may endanger women's health or have adverse effects on their future role as mothers. Employment in these occupations and jobs may therefore be totally prohibited or may be allowed subject to the existence of specified conditions of work, and then only after medical examination.⁵⁵⁰

Italy

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme. This includes the free issue of pharmaceutical and other relevant supplies.⁵⁵¹

Employment During Pregnancy

Work considered dangerous to pregnancy, such as the carrying and lifting of loads, is prohibited to pregnant women and to mothers during the seven months following confinement.⁵⁵²

Pregnant workers have the right to be transferred to another post and work compatible with their condition, without loss of wages. Pregnant women also have the right to transfer for individual reasons. As a rule, all that is needed for such a transfer is a medical certificate saying that it is necessary. When such transfer is not possible, the date of the normal start of maternity leave may be brought forward.⁵⁵³

Luxembourg

Employment During Pregnancy

Night work is specifically prohibited for pregnant women and nursing mothers.⁵⁵⁴

Overtime work for pregnant women and nursing mothers is prohibited.⁵⁵⁵

Netherlands

Status of the Fetus

In the Netherlands, no legal basis exists for fetal apprehension. According to Section II of the Constitution, the human body is inviolable. However, the section applies to living persons only. Therefore, in the case of harmful behaviour by a woman, no intervention can be made on behalf of the fetus.⁵⁵⁶

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁵⁵⁷

Norway

Employment During Pregnancy

Current legislation in Norway is marked by an almost total absence of protective legislation for women. However, Norway has ratified the ILO Convention concerning White Lead (Painting) (No. 13).⁵⁵⁸

Poland

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme. This includes the free issue of pharmaceutical and other relevant supplies.⁵⁵⁹

Romania

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme.⁵⁶⁰

Spain

Medical Care During Pregnancy

Working women are entitled to full free medical assistance before, during, and after confinement.⁵⁶¹

Sweden

Medical Care During Pregnancy

Health care offered in the Centres for Maternal and Child Protection has been free since the 1970s. The same is true for obstetrical care. The centres offer regular schedules of health care and diverse forms of prenatal preparation.⁵⁶²

Alcohol and Drugs

The law concerning treatment of alcoholics and drug addicts authorizes the involuntary placement of addicts in care for a period of two months, which can be extended for another two months under certain conditions.⁵⁶³

Employment During Pregnancy

Current legislation in Sweden is marked by an almost total absence of protective legislation for women. Sweden did ratify the ILO Convention prohibiting underground work by women (No. 45) in 1936 but renounced it in 1967. It has ratified the White Lead (Painting) Convention (No. 13).⁵⁶⁴

There are special rights for pregnant women to be transferred to jobs that do not involve physical strain from the sixtieth day preceding confinement.⁵⁶⁵ Employers and trade unions have agreed that if a pregnant woman requests a transfer from a job requiring operation of a VDU, the employer will comply to the best of its ability. The agreement acknowledges that there is no hard scientific evidence linking VDUs with fetal abnormalities.

Pregnant women whose working ability has been reduced in relation to normal by reason of their pregnancy and who cannot find appropriate

employment have a right to a pregnancy allowance at the same rate as parental allowance [90 percent of gross revenue] for a maximum of 50 days before the expected date of delivery.⁵⁶⁶

Switzerland

Employment During Pregnancy

Women may not be employed to work underground in mines and galleries, and their employment in certain harmful or dangerous jobs is also prohibited.⁵⁶⁷

An employer must have "due regard" for a woman's health and has to make arrangements to safeguard her morals. Women are prohibited from working with machines, tools, and apparatus that involve a great risk of accidents or require too strenuous an effort for women. The spread of a woman's daytime work may not exceed 12 hours, and the rest period must include at least 11 consecutive hours. Women may not be ordered to work at night or on a Sunday. Women running a household must be given a midday break of at least one and a half hours if they so request.⁵⁶⁸

USSR⁵⁶⁹

Constitutional Principles

It is a principle of state policy in the USSR to provide all possible social and legal guarantees to enable women to combine economic, social, and political activity with motherhood.⁵⁷⁰

Medical Care During Pregnancy

Medical care, including prenatal, confinement, and post-natal care, is provided free through an insurance or public health scheme, which includes the free issue of pharmaceutical and other relevant supplies.⁵⁷¹

Employment During Pregnancy

The main feature of the legal regulation of women's work in the USSR is the restriction on the employment of women in certain types of work. It is unlawful to employ women in certain arduous and unhealthy jobs, with the evaluation being made on the basis of physical strain, lifting and moving loads, and the presence of toxic chemicals. Women are also prevented from working underground. All women excluded from jobs involving risk to their health are transferred to new jobs after a period of retraining during which they retain seniority and earnings.⁵⁷²

Pregnant working women may not be assigned overtime or night work or sent on business trips.⁵⁷³ In enterprises where there is a majority of female workers, special measures have been introduced for pregnant women, including flexible working hours, a shorter work week, lowered production standards, facilities for resting, and *constant observation* by an obstetrician-gynaecologist.⁵⁷⁴

European Economic Community

European Social Charter (1961)⁵⁷⁵

Among the stated principles underpinning the Charter is that employed women, in the case of maternity, and other employed women as appropriate, have the right to special protection in their work [Part I, para. (8)]. Article 8 requires the parties

1. to provide paid maternity leave, to be taken before and after childbirth, of at least 12 weeks;
2. to make it unlawful for an employer to dismiss a woman during her maternity leave;
3. to provide time off work for nursing;
4. (a) to regulate the employment of women workers on night work in industrial employment;
 (b) to prohibit the employment of women workers in underground mining, and, as appropriate, on all other work that is unsuitable for them by reason of its dangerous, unhealthy, or arduous nature.

It has been recognized that paragraph (2) is not an absolute prohibition, and a pregnant woman may still be dismissed for misconduct that justifies breaking off the employment relationship, if the business concerned ceases to operate, or if the period prescribed in the employment contract has expired.

Case law has clarified that the reference to industrial undertakings in paragraph (4) does not mean non-industrial work in industrial undertakings; underground mining does not include underground non-mining work by women working as social workers, nurses, doctors, etc.

Recently, in *Dekker v. VJV-Centrum*,⁵⁷⁶ the Court of Justice held that pregnancy discrimination is sex discrimination.

European Convention on Human Rights

Article 2, paragraph 1, of the convention states: "Everyone's right to life shall be protected by law." Article 2 does not recognize an absolute right to life of the fetus. Even assuming the provision applies to fetal life at the initial stages of pregnancy, an abortion is covered by an implied limitation protecting the life and health of the woman.⁵⁷⁷

Article 8, paragraph 1, of the convention states: "Everyone has the right to respect for his private and family life, his home and his correspondence." There are limits on the scope of this guarantee, to the extent that the individual brings his private life into contact with public life or into close connection with other protected interests. Pregnancy and its interruption do not, as a matter of principle, pertain uniquely to the sphere of private life of the mother.⁵⁷⁸

There is an implicit limitation on a fetus's right to life arising from the necessity of protecting the life and health of the mother.⁵⁷⁹

The EEC Council's *Directive Laying Down the Basic Standards for the Protection of the Health of Workers and the General Public Against the Dangers Arising from Ionizing Radiations* requires that "during pregnancy or the nursing period, women must not be employed in work involving risk of high exposure"; it sets exposure limits and provides that no woman of reproductive capacity may be subjected to planned abnormal external and internal exposures. It also mandates pre-employment medical examinations of job applicants.⁵⁸⁰

The *Directive on the Protection of Workers from the Risks Related to Exposure to Metallic Lead and Its Ionic Compounds* adopts one standard equally applicable to men and women, without differentiation on the basis of sex or age or reproductive function.⁵⁸¹

In 1987, the Council of Ministers of Social Affairs recommended to member states that protective measures be considered a form of discrimination and eliminated if possible. The EEC confirmed the possibility of retaining special provisions relating to pregnancy and motherhood, with exceptions being interpreted in a restrictive manner and with protective legislation being extended to men whenever necessary.⁵⁸²

Other International Conventions and Agreements

International Labour Organization

*Convention Concerning the Employment of Women Before and After Childbirth (Maternity Protection Convention) 1919*⁵⁸³

This convention applies to any women working in public or private industrial or commercial undertakings and creates a right to maternity leave, both before and after confinement; to benefits during maternity leave; to free medical care; and to time off for nursing (Article 3). Article 4 of the convention makes it unlawful to give an employee notice of dismissal during her maternity leave.

*Maternity Protection Convention (Revised) 1952*⁵⁸⁴

This convention applies to all women working in industrial undertakings and in non-industrial and agricultural occupations, including women wage earners working at home (although Article 7 permits each ratifying country to exempt occupations or undertakings).

Article 3 states that a woman shall be entitled to maternity leave of 12 weeks, including a compulsory period of at least 6 weeks of leave after giving birth. Article 4 describes minimum cash and medical benefits that a woman absent on maternity leave is entitled to receive from public funds or from some form of social insurance. Article 5 provides that nursing mothers shall be entitled to interrupt their work for this purpose for such times and durations as are set by each country and that such periods are to be counted as working hours.

Article 6 is the employment protection clause, which provides that an employer may not give a woman notice of dismissal when she is absent on maternity leave.

The convention was accompanied by the Maternity Protection Recommendations, 1952. It was recommended that the period of maternity leave be extended to 14 weeks, with provision for further extensions in case of medical necessity; that the cash and medical benefits should whenever practicable be fixed at a level higher than the minimum established in the convention; that the "nursing hours" should be at least one and a half hours daily; and that the protection from dismissal should begin from the time the employer is notified of the pregnancy. Lastly, it was recommended that a woman's working hours be planned so as to allow adequate rest periods and that any work prejudicial to her health should be prohibited during pregnancy and while nursing.

*United Nations — Declaration on the Elimination of Discrimination Against Women (1967)*⁵⁸⁵

Article 10 of the declaration urges that all appropriate measures be taken to ensure to women, married or unmarried, equal rights with men in the field of economic or social life. In order to ensure women's effective right to work and to prevent discrimination on the basis of marriage or maternity, paragraph 2 specifies that measures should be taken to prevent dismissal of women in the event of marriage or maternity and to provide paid maternity leave, with the guarantee of returning to former employment.

Article 10 further states that measures taken to protect women in certain types of work, for reasons inherent in their physical nature, shall not be regarded as discriminatory.

*United Nations — Convention on the Elimination of All Forms of Discrimination Against Women (1979)*⁵⁸⁶

To implement the principles set out in the Declaration on the Elimination of Discrimination Against Women, the parties to this UN convention agreed to pursue that goal by all appropriate means.

The convention specifies that adoption of special measures aimed at protecting maternity shall not be considered discriminatory (Article 4, para. 2).

In the field of employment, Article 11 recognizes as a right of both men and women the protection of health and safety in working conditions, including the safeguarding of the function of reproduction (para. 1.f). Paragraph 2 goes on to list specific steps that should be taken to ensure women their effective right to work:

- (a) to prohibit dismissal on the grounds of pregnancy or of maternity leave;

- (b) to introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority, or social allowances;
- (c) to provide special protection to women during pregnancy in types of work proved to be harmful to them.

Article 12 requires states that are party to the convention to ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Notes

1. *Ackerman v. McGoldrick*, [1990] B.C.J. No. 2832 (Prov. Ct.); *Re A. (in utero)* (1990), 75 O.R. (2d) 82; *Re Baby R.* (1988), 53 D.L.R. (4th) 69 (B.C.S.C.), rev'd (sub nom. *Re R.*) (1987), 9 R.F.L. (3d) 415 (Prov. Ct.); *R. v. MacKenzie* (3 August 1988) (Ont. Prov. Ct., Hogg, J.), discussed in T.B. Dawson, "Re Baby R: A Comment on Fetal Apprehension," *Canadian Journal of Women and the Law* 4 (1990): 265-75; *Joe v. Director of Family and Children's Services (Yukon)* (1987), 1 Y.R. 169; *Re Children's Aid Society of City of Belleville, Hastings County and T. et al.* (1987), 59 O.R. (2d) 204; *J.M. v. Superintendent of Family and Child Services* (1983), 35 R.F.L. (2d) 364 B.C.C.A., affg (sub nom. *Re Superintendent of Family and Child Services and McDonald*) (1982), 135 D.L.R. (3d) 330 (B.C.S.C.); *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249.
2. For a detailed analysis, see M. Jackman, "The Canadian Constitution and the Regulation of New Reproductive Technologies," in *Overview of Legal Issues in New Reproductive Technologies*, vol. 3 of the research studies of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Supply and Services Canada, 1993).
3. For a discussion of the jurisdiction over reproductive health care, see S.L. Martin, *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms, and the Canada Health Act* (Ottawa: Canadian Advisory Council on the Status of Women, 1989), 3-8; Jackman, *op. cit.*
4. Except for those hospitals that are specifically federal in nature under section 91(11).
5. *RWDSU v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573 at 592; *R. v. Therens*, [1985] 1 S.C.R. 613 at 645, cited with approval by Lamer, C.J. in *R. v. Swain*, [1991] 1 S.C.R. 933.
6. For an excellent discussion of the constitutional validity of interference with reproductive autonomy, see I. Grant, "Forced Obstetrical Intervention: A Charter Analysis," *University of Toronto Law Journal* 39 (1989): 217-57; Jackman, *supra*, note 2.
7. *Tremblay v. Daigle*, [1989] 2 S.C.R. 530; *R. v. Sullivan and LeMay*, [1991] 1 S.C.R. 489. *Re Baby R.*, *supra*, note 1; *Re A. (in utero)*, *supra*, note 1; *Seede et al. v. Camco Inc.* (1985), 50 O.R. 2d 218, (1986), 55 O.R. (2d) 352. For an insightful

comment on the reasons for judgment in the *Daigle* case, see D. Greschner, "Abortion and Democracy for Women: A Critique of *Tremblay v. Daigle*," *McGill Law Journal* 35 (1990): 633-69.

8. Similar conclusions have been reached by courts considering whether the fetus is entitled to protection at common law in the absence of statutory provisions specifying the entities to which or to whom protection is to be extended. For a discussion of the common-law principles and their counterparts in the civil law of the province of Quebec, see *Tremblay v. Daigle*, op. cit. *Dehler v. Ottawa Civic Hospital* (1979), 101 D.L.R. (3d) 686; *Medhurst v. Medhurst* (1984), 9 D.L.R. (4th) 252; *Diamond v. Hirsch* (6 July 1989) (Man. Q.B.), unreported. For similar conclusions in other jurisdictions, see *Paton v. British Pregnancy Advisory Service Trustees*, [1979] Q.B. 276; C. v. S., [1987] 1 All E.R. 1230 (Great Britain); *Attorney General v. T.* (1983), 46 A.L.R. 275; F. v. F., Family Court of Australia (12 July 1989), unreported (Australia); *Paton v. United Kingdom* (1981) 3 E.H.R.R. 408 (European); *McCollis v. Amica Mutual Insurance Company* (1991) 587 A 2d 67 (foetus is not a person); *Seef v. Sutkus* (1991) 583 N.E. 2d 510 (foetus is included) (United States).

9. *Re Baby R.*, *supra*, note 1; *Re A. (in utero)*, *supra*, note 1.

10. *R. v. Sullivan and LeMay*, *supra*, note 7.

11. (1988), 37 C.C.C. (3d) 449.

12. Other cases interpreting the scope of the language include *Re Cadeddu and The Queen* (1982), 4 C.C.C. (3d) 97 (Ont. H.C.); *Reference re s. 94(2) of the Motor Vehicle Act (B.C.)*, [1985] 2 S.C.R. 486; *R. v. Videoflicks Ltd.* (1984), 30 C.C.C. (3d) 385; *Mills v. The Queen*, [1986] 1 S.C.R. 863.

13. "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (emphasis added).

14. *Supra*, note 5.

15. *Ibid.*, 644. While this statement was made in the context of assessing a detention under section 10 of the Charter, it is referred to by Chief Justice Dickson in the context of section 7. Dickson also refers to statements made by Justice Lamer in the context of section 11(b) as well as to statements of Lamer concerning the inter-relatedness of sections 8-14. It seems appropriate to conclude that Dickson defines the parameters of section 7 protection to include the protection of physical and psychological integrity as described in those cases.

16. *Supra*, note 11, 466. See also Justice Beetz at 491: "A pregnant woman's person cannot be said to be secure if, when her life or health is in danger, she is faced with a rule of criminal law which precludes her from obtaining effective and timely medical treatment."

17. N. MacCormick, *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Oxford: Oxford University Press, 1982), 39, quoted by Wilson at 549.

18. *Ibid.*, 41.

19. *Supra*, note 11, 550.

20. *Ibid.*, 551. See also *Children's Aid Society of Peel (Region) v. S. (P.)* (1991), 34 R.F.L. (3d) 157; *J.S.C. and C.H.C. v. Wren* (1986) 49 Alta. L.R. (2d) 289. In each of

these cases, the right of an adolescent in the custody of Children's Aid Society to a therapeutic abortion on her own consent was upheld.

21. *Ibid.*, at 556.

22. *Ibid.*

23. *Ibid.*

24. *Ibid.*, 558.

25. *Ibid.*, 561.

26. The third test is provided by the saving language of section 1 of the Charter, which provides that:

1. *The Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

27. Dickson, J. in *Morgentaler*, *supra*, note 11, 471; see also *Reference re s. 94(2) of the Motor Vehicle Act*, *supra*, note 12, 499.

28. "I believe, therefore, that a deprivation of the s. 7 right which has the effect of infringing a right guaranteed elsewhere in the Charter cannot be in accordance with the principles of fundamental justice." Wilson, J. in *Morgentaler*, *supra*, note 11, 558.

29. "The question, therefore, is whether the deprivation of the s. 7 right is in accordance not only with procedural fairness ... but also with the fundamental rights and freedoms laid down elsewhere in the *Charter*." Wilson, *op. cit.*, 557. Justice Wilson makes this observation in the context of a section 2 violation, and there is language in the reasons for judgment of Chief Justice Lamer suggesting that a violation of section 8-14 would have the same effect. However, there is nothing to suggest that violation of other sections of the Charter, among them sections 15 and 28, might not have the same impact.

30. Wilson, J. in *Reference re s. 94(2) of the Motor Vehicle Act*, *supra*, note 12, 523. See also Wilson, J. in *Thomson Newspapers Ltd. v. Canada (Director of Investigation and Research, Restrictive Trade Practices Commission)*, [1990] 1 S.C.R. 425.

31. *Supra*, note 5.

32. La Forest, J. in *Jones v. The Queen*, [1986] 2 S.C.R. 284 at 304, cited by Beetz, J. in *Morgentaler*, *supra*, note 11, 507. Emphasis added by Mr. Justice Beetz.

33. *Morgentaler*, *op. cit.*, 507.

34. [1989] 1 S.C.R. 1219.

35. [1989] 1 S.C.R. 143.

36. *Ibid.*, 164.

37. *Ibid.*, 165.

38. *Ibid.*, 174-75.

39. *Ibid.*, 152.

40. *R. v. Turpin*, [1989] 1 S.C.R. 1296 at 1331.

41. *Ibid.*, 1333.

42. [1990] 2 S.C.R. 906.
43. *Ibid.*, 928.
44. See also *R. v. Seaboyer*, [1991] 2 S.C.R. 577 (striking down the rape-shield provisions), suggesting that “outmoded, sexist-based” assumptions might violate section 7 of the Charter, but failing to so find in the case.
45. Alberta: Individual's Rights Protection Act, R.S.A. 1980, c. I-2; British Columbia: Human Rights Act, S.B.C. 1984, c. 22; Saskatchewan: Saskatchewan Human Rights Code, S.S. 1979, c. S-24; Manitoba: Human Rights Code, S.M. 1987, c. 45; Ontario: Human Rights Code, S.O. 1981, c. 53; Quebec: *Charte des droits et libertés de la personne*, L.R.Q. 1977, C-12; New Brunswick: Human Rights Act, R.S.N.B. 1973, c. H-11; Nova Scotia: Human Rights Act, R.S.N.S. 1989, c. 214; Prince Edward Island: Human Rights Act, S.P.E.I. 1975, c. 72; Newfoundland: Human Rights Code, S.N. 1988, c. 62; Northwest Territories: Fair Practices Act, R.S.N.W.T. 1974, c. F-2; Yukon: Human Rights Act, S.Y. 1987, c. 3.
46. [1985] 2 S.C.R. 536.
47. *Ibid.*, 551.
48. *Supra*, note 35, 173.
49. *Supra*, note 34, 1242.
50. *Ibid.*, 1238.
51. The Human Rights Code, S.M. 1987, c. 45. See also Human Rights Act, S.Y. 1987, c. 3, s. 6(f) “sex, including pregnancy, and pregnancy related conditions.”
52. An Act to Amend the Human Rights Act, S.N.B. 1992, c. 30, s. 2.
53. C.B. Backhouse, “Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada,” *Windsor Yearbook of Access to Justice* 3 (1983), 62.
54. An Act Relating to Treasons and Felonies (1758) 32 Geo. II, c. 13, s. 5 (N.S.); An Act Relating to Treasons and Felonies (1792) 33 Geo. III, s. 1, s. 5 (P.E.I.).
55. See C.B. Backhouse, “Desperate Women and Compassionate Courts: Infanticide in Nineteenth-Century Canada,” *University of Toronto Law Journal* 34 (1984): 447-78.
56. An Act for the further Prevention of malicious shooting, and attempting to discharge loaded Fire-Arms ... and also for repealing ‘An Act to prevent the destroying and murdering of Bastard Children’, (1803) (Eng.), 43 Geo. III, c. 58, s. 3, 4.
57. For a complete history of the provisions on infanticide, see Backhouse, *supra*, note 55.
58. An Act Respecting Offenses Against the Person (1869) 32 & 33 Vict., c. 20, s. 61, 62 (Dominion of Canada). See also Backhouse, *op. cit.*, 455.
59. Section 233 Criminal Code, R.S.C. 1985, c.C-46. See also section 237, which imposes a penalty of not more than five years. See also section 663 providing for conviction of causing the death of a child where the exculpatory requirements of lactation or disturbance of the mind required for the infanticide offence cannot be established. See *R. v. Smith* (1976), 32 C.C.C. (2d) 224 for a discussion of the required elements of the offence of infanticide.

60. Section 238. The maximum applicable penalty is life imprisonment.
61. Section 242. The penalty is not to exceed imprisonment for five years.
62. Section 243. The penalty is not to exceed two years. On the numerous and poorly organized nature of these offences, see Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper 58 (Ottawa: LRC, 1989). On the political and social purposes of the various offences, see Backhouse, *supra*, note 53, 130.
63. For studies of the origins of the Canadian abortion prohibition, see S. Gavigan, "The Criminal Sanction as It Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion," *Journal of Legal History* 5 (1984): 20-43; The Abortion Prohibition and the Liability of Women: Historical Development and "Future Prospects," thesis, York University, Osgoode Hall Law School, 1984; S. Gavigan, "Women and Abortion Law in Canada: What's Law Got to Do with It?" in *Feminism and Political Economy*, ed. H.J. Maroney and M. Luxton (Toronto: Methuen, 1987), 263. S. Rodgers, "Regulation of Abortion in Canadian Law" (Ottawa: University of Ottawa, Faculty of Law, n.d.).
64. An Act for the further prevention of malicious shooting, and attempting to discharge loaded fire-arms, ... and the malicious using of Means to procure the Miscarriage of Women, 1803 (Eng.), 43 Geo. III, c. 53, ss. 1, 2.
65. An Act ... for the further prevention of the malicious using of means to procure the miscarriage of women, 1810 (N.B.), 50 Geo. III, c. 2.
66. An Act to amend the Statute Law, relative to offences against the Person ..., 1829 (N.B.), 9 & 10 Geo. IV, c. 21, s. 8.
67. An Act to extend the Criminal Laws of England to this Colony, 1837 (Nfld.) 1 Vict., c. 4, s. 2.
68. An Act further to amend the Law relating to Offences against the Person, 1842 (N.B.), 5 Vict., c. 33, s. 2.
69. An Act for consolidating ... Offences against the person, 1841 (Upper Can.), 4 & 5 Vict., c. 27, s. 13; An Act respecting Offences against the Person, 1859 C.S.C. (Can.), 22 Vict., c. 91, s. 24.
70. An Act respecting Offences against the Person, 1869 (Can.), 32 & 33 Vict., c. 20, ss. 59, 60.
71. The Criminal Code, 1892 (Can.), 55 & 56 Vict., c. 29, ss. 272-274.
72. Section 219 provided that

A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not. The killing of such child is homicide, when it dies in consequence of injuries received before, during or after birth.

This is the same section that was at issue in the recent case of *R. v. Sullivan and Lemay*, *supra*, note 7.

73. The Criminal Code, 1892, 55 and 56 Vict., c. 29, s. 179(c). Professor Backhouse argues that in defining contraceptives and abortifacient as obscene, "the Canadian statute went far beyond anything yet seen in English legislation." For an

explanation of the reasons for prohibiting the use of contraceptives, see Backhouse, *supra*, note 53, 119; W. Hutchinson, "Historical Attitudes Toward Women and Childbirth," *Atlantis* 4 (2)(1979): 13.

74. See, generally, C.L.M. Boyle, *Sexual Assault* (Toronto: Carswell, 1984), 45 seq. And see section 143, Criminal Code of Canada, repealed 1980-81-82, c. 129, s. 19.

75. See the work of A. McLaren and A.T. McLaren, *The Bedroom and the State* (Toronto: McClelland and Stewart, 1986).

76. *Ibid.* See also S.A.M. Gavigan, "On 'Bringing on the Menses': The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law," *Canadian Journal of Women and the Law* 1 (1986): 279; Backhouse, *supra*, note 53; Gavigan, "The Criminal Sanction," *supra*, note 63. On infanticide, see Backhouse, *supra*, note 55. On the operation of the abortion law, see Canada, Department of Justice, Committee on the Operation of the Abortion Law, *Report* (Ottawa: Minister of Supply and Services Canada, 1977); Ontario, Ministry of Health, *Report on Therapeutic Abortion Services in Ontario* (Toronto: The Ministry, 1987).

77. *Crimes Against the Foetus*, *supra*, note 62, 18. See also Law Reform Commission of Canada, *Homicide*, Working Paper 33 (Ottawa: LRC, 1984); Law Reform Commission of Canada, *Recodifying Criminal Law*, Report 31 (Ottawa: LRC, 1987). The author of this study does not share the perspective of the Law Reform Commission of Canada, as expressed in *Crimes Against the Foetus*, nor the legal analysis expressed therein, nor the historical conclusions that the report draws. For critiques of that report, see M.L. McConnell, "Capricious, Whimsical, and Aborting Women: Abortion as a Medical Criminal Issue (Again)," *Canadian Journal of Women and the Law* 3 (1989-90): 661-66; S. Noonan, "Protection of the Foetus: Denial of the Woman," *Canadian Journal of Women and the Law* 3 (1989-90): 667-72.

78. Sections to be repealed would include: 223 — definition of human being; 238 — killing during the act of birth; 242 — neglecting to obtain assistance in childbirth; 243 — concealing the body of a child; 287 — abortion; 288 — supply of a noxious thing.

79. *Crimes Against the Foetus*, *supra*, note 62, 51.

80. "Where, however, destruction or harm to the foetus is caused by the mother herself, we feel that the requisite culpability should be limited to purpose. While few perhaps would deny that pregnant women have a moral obligation to avoid reckless or negligent conduct affecting their foetuses, we hesitate to bring in criminal law at this point. In the first place, because of the unique relationship between mother and foetus, use here of criminal law would — unfairly in our view — impose special burdens on her over and above those falling on all other parties. Second, criminal law enforcement would involve intolerable restrictions on the mother's own autonomy, e.g., monitoring the way she eats, drinks, smokes and so on. Third, such monitoring and restrictions could well cause marital and familial disruption. Finally, at a time when pregnant women's civil liability for foetal injuries is far from resolved, it would be premature to impose on them the still more onerous burden of criminal liability." *Ibid.*, 52.

81. See McConnell, *supra*, note 77; Noonan, *supra*, note 77.

82. Canada, Department of Justice, *supra*, note 76; Ontario, Ministry of Health, *supra*, note 76. See also the historical work by Backhouse, *supra*, notes 53, 55; and Gavigan, *supra*, notes 63, 76.

83. See, for example, A. Klein and W. Roberts, "Besieged Innocence: The 'Problem' and the Problems of Working Women, Toronto, 1896-1914," in *Women at Work, Ontario, 1850-1930*, ed. J. Acton, P. Goldsmith, and B. Shepard (Toronto: Canadian Women's Educational Press, 1974), 222:

When I tell you that today we have in this province, women working in the foundries, machine shops, and breweries, some of the weaker sex, and not a few of their champions will be surprised. I do not mention this as meaning to say that labour for women and children is degrading, but rather to show ample reason why they should be protected ... the effect on propagation by the present race and the degeneration of future generations.

84. Canada, Royal Commission on Equality in Employment, *Report* (Ottawa: Minister of Supply and Services Canada, 1984); P. Armstrong and H. Armstrong, *The Double Ghetto: Canadian Women and Their Segregated Work* (Toronto: McClelland and Stewart, 1978).

85. See also K. Swinton, "Accommodating Women in the Workplace: Reproductive Hazards and Seniority Systems," *Canadian Labour Law Journal* 1 (1992): 124-39. See also *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)* (1990), 72 D.L.R. (4th) 417 (S.C.C.).

86. See Canada, Health and Welfare Canada, *The Pregnant Worker: A Resource Document for Health Professionals* (Ottawa: Federal-Provincial Advisory Committee on Environmental and Occupational Health, 1991); N.M. Chenier, *Reproductive Hazards at Work: Men, Women and the Fertility Gamble* (Ottawa: Canadian Advisory Council on the Status of Women, 1982); Canada, Labour Canada, Women's Bureau, *Canadian Women and Job Related Laws* (Ottawa: Women's Bureau, 1981); Ontario Ministry of Labour, *Working in Ontario — An Employee's Guide to Working in Ontario* (Toronto: Queen's Printer for Ontario, 1990); G.B. Doern, *Regulatory Processes and Jurisdictional Issues in the Regulation of Hazardous Products in Canada*, Science Council of Canada Background Study 41 (Ottawa: Minister of Supply and Services Canada, 1977); Science Council of Canada, *Politics and Poisons: The Containment of Long-Term Hazards to Human Health in the Environment and in the Workplace* (Ottawa: Science Council of Canada, 1977); J.D. Johnston, G.G. Jamieson, and S. Wright, "Reproductive and Developmental Hazards and Employment Policies" (unpublished paper on file with the author, 1991); U.S. Congress, Office of Technology Assessment, *Reproductive Health Hazards in the Workplace* (Washington, DC: OTA, 1985); L. Tataryn, *Dying for a Living: The Politics of Industrial Death* (Ottawa: Deneau and Greenberg, 1979); Ontario Advisory Council on Occupational and Environmental Health, Special Studies and Projects Sub-Committee, *Report on Occupational Hazards to the Fetus in the Case of Pregnant Women in the Work Force* (Toronto: 1977); L. Kaye, *Reproductive Hazards in the Workplace: Some Cases* (Ottawa: National Action Committee on the Status of Women, 1986); L. Kaye, *Danger, Keep Out! Exclusionary Hiring Practices by Employers, Reproductive Hazards at Work* (Ottawa: National Association of Women and the Law, 1985).

87. See, for example, V. Beral, "Leukaemia and Nuclear Installations: Occupational Exposure of Father to Radiation May Be the Explanation," *British Medical Journal* (17 February 1990): 411-12; A.F. Olsham, K. Teschke, and P.A. Baird, "Birth Defects Among Offspring of Firemen," *American Journal of Epidemiology* 131 (1990):

312-21; A.J. Wyrobek, "Male Biomarkers of Abnormal Reproductive Outcome," *Health and Environment Digest* 4 (8)(1990): 1-4.

88. *Supra*, note 85.

89. Swinton, *supra*, note 85. Professor Swinton describes at length the implications of describing a woman's reproductive capacity as a physical condition requiring accommodation. She points out that such an argument suggests drawing an analogy between pregnancy and disability, and that to date the case law on reasonable accommodation has generally dealt with the issues raised by accommodation of religious belief. See *Heincke v. Emrick Plastics* (1990), 91 C.L.L.C. para. 17,010 (Ont. — Hovius), aff'd (sub nom. *Emrick Plastics v. Ontario (Human Rights Commission)*) (1992), 90 D.L.R. (4th) 476.

90. The only reference that the author could identify to a collection of those provisions that impact on women's reproductive capacity and the implications of that capacity in the workplace is: *Canadian Women and Job Related Laws*, *supra*, note 85. No update of this text is available. See also *The Pregnant Worker: A Resource Document for Health Professionals*, *supra*, note 86.

91. "Ministry Says Woman Can Refuse Work That Puts Fetus in Jeopardy," *Globe and Mail* (18 December 1982): 4.

92. SOR/DOR/85-335. *Canada Gazette*, Part II, Vol. 119, No. 9, p. 1884, Table I.

93. *Ibid.*, s. 3.

94. Radiation Protection Act, R.S.A. 1985, c. R-2.1.

95. Radiation Protection Regulation, Alberta Regulation 162/90, 27 June 1990.

96. *Ibid.*, s. 5(2)(a).

97. Section 5(2)(b) "... the maximum exposure limit to ionizing radiation for a fetus or embryo shall be limited, during the time that the pregnancy is known, to 0.6 mSv for any 2-week period."

98. Schedule 1, Annual Maximum Exposure Limits for Ionizing Radiation.

99. Occupational Health and Safety Act, R.S.N.S. 1989, c. 320.

100. Section 49(1)(c).

101. *Code of Practice for Working with Lead*, April 1991 [pursuant to the Occupational Health and Safety Act, R.S.N.S. 1989, c. 320].

102. Table A-2 Action Criteria for Blood Lead Observations.

103. Letter on file with the author, dated 27 June 1991.

104. Schedule "A," Occupational Health Regulations, Section 11, c. 247, s. 4, approved 21 December 1976. American Conference of Governmental Industrial Hygienists, *Threshold Limit Values for Chemical Substances and Physical Agents and Biological Exposure Indices* (Cincinnati: ACGIH, 1990-91).

105. U.S. National Council on Radiation Protection and Measurements, *Basic Radiation Protection Criteria*, NCRP Report 39 (Washington, DC, 1971).

106. *Ibid.*, 92.

107. *Ibid.*, 89.

108. *Ibid.*, 93.

109. R.S.O. 1980, c. 321.
110. O. Reg. 632/86.
111. Section 10(2).
112. Technical Guide, 71-72.
113. Ibid., 73.
114. Ibid., 74.
115. O. Reg. 536/81 as amended by O. Reg. 23/87; *Designated Substances in the Workplace: A Guide to the Lead Regulation* (Toronto: Ontario Ministry of Labour, 1985).
116. O. Reg. 141/82 as amended by O. Reg. 23/87.
117. Section 4 (a)(i).
118. An Act for the Promotion and Protection of the Health and Safety of Persons Engaged in Occupations, R.S.S. 1978, c. O-1.
119. Occupational Health and Safety Branch, Regina, Saskatchewan, 1991.
120. Ibid.
121. Occupational Health and Safety Branch, Regina, Saskatchewan, 1990.
122. Saskatchewan *Gazette*, 7 March 1989.
123. Section 14(4).
124. An Act Respecting Occupational Health and Safety, R.S.Q., c. S-2.1 as amended. Section 40 provides: "A pregnant worker who furnishes to her employer a certificate attesting that her working conditions may be physically dangerous to her unborn child, or to herself by reason of pregnancy, may request to be re-assigned to other duties involving no such danger that she is reasonably capable of performing."
125. Section 46 provides: "A worker who furnishes to her employer a certificate attesting that her working conditions involve risks for the child she is breast-feeding may request to be re-assigned to other duties involving no such risks that she is reasonably capable of performing."
126. S. Belanger, "Le retrait préventif de la travailleuse enceinte," *Canadian Journal of Women and the Law* 1 (1986): 498-504.
127. "Vu dans cette optique, c'est la travailleuse enceinte qui constitue le danger puisque c'est elle que l'on retire, sans jamais inciter de véritables mesures préventives dans le milieu." Ibid., 500.
128. Ibid.
129. Ibid., 503.
130. Section 12(1).
131. Section 12(2).
132. S.N.B. 1980, c. F-2.2.
133. J.A. MacKenzie, *Judicial Intervention in Human Reproductive Processes: A Policy Profile*, study prepared for the Royal Commission on New Reproductive Technologies, 1991, 67.

134. Quoted in MacKenzie, *op. cit.*, 68.
135. S.Y. 1984, c. 2, s. 134 (1).
136. *Supra*, note 1. These provisions are under study. A report is expected in 1992.
137. An Act Respecting Consent to Medical Treatment, R.S.N.S. 1989, c. 279.
138. Bill 8, An Act Respecting Natural Death, 39 Elizabeth II, 1990, s. 3(3) (Ont.).
139. See Bill 108, An Act to Provide for the Making of Decisions on Behalf of Adults Concerning the Management of Their Property and Concerning Their Personal Care, 40 Elizabeth II, 1991 (Ont.); Bill 109, An Act Respecting Consent to Treatment, 40 Elizabeth II, 1991 (Ont.).
140. See, for example, resolutions of the 122nd General Council of the Canadian Medical Association, Quebec City, 1989.
141. "Judicially, the status of the human foetus has remained unresolved despite repeated requests by the courts for statutory clarification. Medically, developments in reproductive technology, fetal surgery and related fields are proceeding apace. However, they are taking place in the absence of clear policies that settle the status of the foetus itself." Canadian Medical Association, Committee on Ethics, *The Status of the Human Foetus* (Ottawa: CMA, 1991). The Committee cites *R. v. Morgentaler*, [1988] 1 S.C.R. 30 as an example of this proposition. The view of the author of this study prepared for the Commission is to the opposite effect. In my view, the reasons for judgment of the Supreme Court of Canada in the *Morgentaler*, *Daigle*, and *Sullivan and Lemay* cases are quite clear on the legal status of the fetus in Canadian law as well as on the parameters of the constitutional protection afforded to Canadian women by Canadian law.
142. *Status of the Human Foetus*, *op. cit.*, 202.
143. Ibid.
144. Ibid., 207.
145. Ibid., 208.
146. Ibid., 210.
147. Ibid., 211.
148. Ibid.
149. Ibid., 211-12.
150. Ibid., 215.
151. Ibid. The Committee here cites the position of the American College of Obstetricians and Gynecologists, Committee on Ethics, *Patient Choice: Maternal-Fetal Conflict*, Committee Opinion No. 55 (Washington, DC: ACOG, 1990). The conclusions of the American College with regard to judicial intervention are contrary to those of the Ethics Committee of the Canadian Medical Association.
152. Ibid., 216.
153. Ibid.
154. Ibid., 219, fn. 17.
155. Ibid. See cases cited at 219, footnote 18. More recent jurisprudence is to the contrary. See *Re A. (in utero)* and the *Joe* case, *supra*, note 1. The draft also cites

language from the reasons for judgment of the Supreme Court of Canada in support of its position. See 219-20, footnote 18.

156. See P. Sullivan, "CMA's Discussion Paper on Fetal Rights May Spark Debate," *Canadian Medical Association Journal* 143 (1990): 404-405.

157. At law, the emergency doctrine allows the physician to forgo consent to treatment where consent cannot be obtained. It does not allow the physician to over-ride the refusal of a treatment that a competent adult prefers to forgo, whatever her reasons. This is the case even where the patient subsequently has become incompetent. See *Malette v. Shulman* (1987), 63 O.R. (2d) 243; *R. v. Swain*, *supra*, note 5.

158. The Royal College of Physicians and Surgeons of Canada, Biomedical Ethics Committee, "Reflection on the Physician's Responsibility to Mother and Fetus," submission to the Royal Commission on New Reproductive Technologies, Ottawa, 1990.

159. *Ibid.*, 1.

160. *Ibid.*, 2.

161. *Ibid.*, 3.

162. *Ibid.*

163. *Ibid.*, 6.

164. *Ibid.*

165. Canadian Bar Association, *Submission of the CBA to the Royal Commission on New Reproductive Technologies* (Ottawa: 1990), 73.

166. *Ibid.*, 74.

167. *Ibid.*, 75.

168. *Ibid.*, 77.

169. *Ibid.*, 78.

170. *Ibid.*

171. *Ibid.*, 78-79.

172. Canadian Chemical Producers' Association, "Draft CCPA Guideline on Reproductive and Developmental Hazards in the Workplace" (Ottawa: n.d.), 1.

173. Exxon Corporation is reported to have such a policy. See G.R. LeClerq, "Workplace Reproductive Risk: Corporate Responsibilities," *The Medical Bulletin* 43 (1983): 30-39; N.M. Hanis and S.C. Phillips, "Considerations in the Development of a Reproductive Surveillance System for Exxon," *The Medical Bulletin* 43 (1983): 3-29.

174. There are a number of commentaries on these cases by Canadian legal scholars. For the most part, they are highly critical of judicial interference of this nature, particularly the ones written by women. See Dawson, *supra*, note 1; Grant, *supra*, note 6; C. Overall, "Mother/Fetus/State Conflicts," *Health Law in Canada* 9 (1989): 101-103, 122; S. Rodgers, "Pregnancy as Justification for Loss of Juridical Autonomy," in *The Future of Human Reproduction*, ed. C. Overall (Toronto: Women's Press, 1989), 174; S.A. Tateishi, "Apprehending the Fetus *En Vente Sa Mère*: A Study in Judicial Sleight of Hand," *Saskatchewan Law Review* 53 (1989): 113-41;

C. Overall, "Pluck a Fetus from Its Womb: A Critique of Current Attitudes Toward the Embryo/Fetus," *University of Western Ontario Law Review* 24 (1986): 1-14; S. Rodgers, "Fetal Rights and Maternal Rights: Is There a Conflict?" *Canadian Journal of Women and the Law* 1 (1986): 456-69; E. Keyserlingk, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective* (Montreal: Quebec Research Centre of Private and Comparative Law, 1984); E. Keyserlingk, "Clarifying the Right to Prenatal Care: A Reply to a Response," *Health Law in Canada* 4 (1983): 35-38; E. Keyserlingk, "The Unborn Child's Right to Prenatal Care" (Part I; Part II), *Health Law in Canada* 3 (1982): 10-21; 31-41.

175. However, see the discussion of the proposed feticide offence recommended by the Law Reform Commission of Canada, and the interpretations critical of the proposal discussed above.

176. Dawson, *supra*, note 1, 270.

177. *Supra*, note 1.

178. *Ibid.*, 252.

179. *Ibid.*

180. *Ibid.*, 253.

181. D.M. Steinberg, *Family Law in the Family Courts*, vol. 1, 2d ed. (Toronto: Carswell, 1981), 112.

182. (1982) 135 D.L.R. (3d) 330.

183. *Ibid.*, 335.

184. *Ibid.*

185. Family and Child Service Act, S.B.C. 1980, c. 11, s. 1(a).

186. *Re Superintendent of Family and Child Services*, *supra*, note 182, 335.

187. *Ibid.*, 336.

188. *Ibid.*

189. *Ibid.*, 337.

190. *Ibid.*, 339.

191. *J.M. v. Superintendent of Family and Child Services*, *supra*, note 1.

192. *Ibid.*, 366.

193. This is the description by the Court of Appeal of the reasoning of Judge Proudfoot, *ibid.*, 368. But see P.A. Monture, "A Vicious Circle: Child Welfare and the First Nations," *Canadian Journal of Women and the Law* 3 (1989): 1-17.

194. *Ibid.*, 372.

195. *Supra*, note 1.

196. *Ibid.*, 204.

197. *Ibid.*

198. *Ibid.*, 205.

199. *Ibid.*

200. *Ibid.*, 206.

201. Mental Health Act, R.S.O. 1980, c. 262, s. 10.
202. *Re Children's Aid Society*, *supra*, note 1.
203. *Supra*, note 1.
204. *Re R.* (1987), 9 R.F.L. (3d) 415 (B.C. Prov. Ct.).
205. *Ibid.*, 416.
206. *Ibid.*, 417.
207. *Ibid.*, 420.
208. *Supra*, note 1.
209. *Ibid.*, 74.
210. *Ibid.*
211. *Ibid.*, 75.
212. *Supra*, note 1.
213. *Ibid.*, 83-84.
214. *Ibid.*, 84 seq.
215. S.O. 1984, c. 55.
216. R.S.O. 1980, c. 66.
217. *Re A. (In utero)*, *supra*, note 1, 88.
218. *Supra*, note 7.
219. *Re A. (In utero)*, *supra*, note 1, 91-92.
220. *Ibid.*
221. Family and Child Service Act, *supra*, note 185.
222. *Ackerman v. McGoldrick*, *supra*, note 1.
223. *Re Superintendent of Family Services and McDonald*, *supra*, note 182. See the discussion *supra*.
224. *Ackerman*, *supra*, note 1, 2.
225. *Ibid.*, 3.
226. *Ibid.*
227. *Ibid.*, 4-5.
228. *Ibid.*, 5.
229. *Ibid.*, 10.
230. *Ibid.*, 11.
231. *Ibid.*
232. *Ibid.*
233. *Ibid.*, 14.
234. The remarks of Judge Collings as to apprehension at birth are obiter and are incorrect in law.

235. "The onus of proof is on the Superintendent to satisfy me that the child is in need of protection. That onus includes, where the opinion of an expert is relied on, both the provision of a solid factual basis for that opinion, and the persuading of the Court that a line of coherent reasoning leads from the factual basis to the conclusion offered. In this case I find the factual basis to be meagre and open to attack, and the line of reasoning to be less than compelling." *Ibid.*, 16.
236. On the impact of professional expertise on women throughout history, see B. Ehrenreich and D. English, *For Her Own Good: 150 Years of the Expert's Advice to Women* (New York: Anchor Press, 1978).
237. Dawson, *supra*, note 1, 270.
238. *R. v. MacKenzie*, *supra*, note 1, 7-8, as quoted in Dawson, *op. cit.*, 270.
239. *Supra*, note 135.
240. Section 134(1).
241. *Supra*, note 1.
242. (1979), 24 L.A.C. (2d) 388.
243. *Ibid.*, 389.
244. *Ibid.*, 394.
245. *Ibid.*, 394-95.
246. *Ibid.*, 391-93.
247. *Ibid.*, 393.
248. (1988) 9 C.H.R.R. 4795 (Ont. Bd. of Inq.).
249. *Ibid.*, 4798.
250. *Ibid.*, 4799.
251. *Ibid.*, 4802.
252. *Ibid.*
253. *Ibid.*, 4804.
254. [1979] 1 S.C.R. 183.
255. *Supra*, note 34.
256. As amended 1986, section 9(2).
257. Wiens, *supra*, note 248, 4817.
258. *Ibid.*, 4814.
259. *Ibid.*, 4819.
260. *Ibid.*
261. *Emrick Plastics v. Ontario (Human Rights Commission)* (1992), 90 D.L.R. (4th) 476, affg (sub nom. *Heincke v. Emrick Plastics*) (1990) 91 C.L.L.C. para. 17,010 (Ont. — Hovius).
262. [1982] 1 S.C.R. 202.
263. *Ibid.*, as cited in *Emrick Plastics*, *supra*, note 261, 481.
264. *Ibid.*, 482.

265. *Ibid.*, 472.
266. *Ibid.*, 482.
267. *Ibid.*
268. *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW v. Johnson Controls, Inc.* (1991), 111 S. Ct. 1196. Discussed *infra*.
269. *Ibid.*, 1207, cited in *Emrick Plastics, supra*, note 261, 482.
270. *Wiens v. Inco Metals Co., supra*, note 248, 4819, discussed *supra*, quoted at p. 482.
271. U.S. Constitution, amendment XIV guaranteeing equal protection of the laws.
272. Title VII of the Civil Rights Act, 42 U.S.C. s. 2000e et seq. (1964), as amended by the Pregnancy Discrimination Act, 42 U.S.C. s. 2000(e)(k) (1982).
273. As noted above, a similar sequence of events has occurred in Canada. The Supreme Court of Canada had defined sex-based discrimination as not including pregnancy-based discrimination in the *Bliss* case (*supra*, note 254). Several of the provincial legislatures amended their human rights codes to make it clear that sex discrimination included discrimination on the basis of pregnancy and in some cases reproductive capacity. In *Canada Safeway* (*supra*, note 34), the Supreme Court reversed its earlier ruling to hold that sex discrimination prohibitions were offended by pregnancy discrimination.
274. *Griswold v. Connecticut* (1965), 381 U.S. 479. See also *Loving v. Virginia* (1967), 388 U.S. 1 (marriage); *Skinner v. Oklahoma* (1942), 316 U.S. 535 (procreation); *Eisenstadt v. Baird* (1972), 405 U.S. 438 (contraception); *Prince v. Massachusetts* (1944), 321 U.S. 158 (family relations). "If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt v. Baird, op. cit.*, 453.
275. (1973), 410 U.S. 113.
276. (1973), 410 U.S. 179.
277. *Webster v. Reproductive Health Services* (1989), 109 S. Ct. 3040.
278. See *supra*, section entitled "The Canadian Charter of Rights and Freedoms."
279. *San Antonio Independent School District v. Rodriguez* (1973), 411 U.S. 1; *Griswold, supra*, note 274, 497.
280. The concept of careful assessment where state imposition of criminal sanctions is at issue is reflected in the language of the Supreme Court of Canada in the *Morgentaler* case concerning the rights of persons to constitutional protection faced with the possible imposition of criminal penalties. See *R. v. Morgentaler, supra*, note 11.
281. U.S. Constitution, amendment XIV, s. 1.
282. *Craig v. Boren* (1976), 429 U.S. 190 at 197. This may be contrasted to classification on the basis of race, which is subject to strict scrutiny and requires that government objectives be compelling and necessary to achieve the statutory

objective. See W.R. Engles, "The 'Substantial Relation' Question in Gender Discrimination Cases," *University of Chicago Law Review* 52 (1985): 149-76.

283. The similarly situated test was rejected by the Supreme Court of Canada in the *Brooks v. Canada Safeway* case.

284. For an application of these doctrines to criminal statutes imposing liability on women for harm to the fetus, see R. Manson and J. Marolt, "A New Crime, Fetal Neglect: State Intervention to Protect the Unborn — Protection at What Cost?" *California Western Law Review* 24 (1988), 178. Manson and Marolt conclude that criminal statutes for fetal neglect would survive neither the "similarly situated" nor the "gender neutral" test.

285. *Roe v. Wade*, *supra*, note 275, 157-58.

286. Analysis of the high level of public interference with the lives of certain pregnant women is complicated and has been the subject of important feminist literature. It is far from clear that an interest in the protection of fetuses and children is the dominant motivating factor in this upsurge of activity, nor that such activity would achieve such protective ends. Furthermore, there is clearly different interference into the lives of women who are poor and of colour.

287. *Key Battle in War on Drugs: Saving Pregnant Women, Endangered Babies*, State Health Notes (Washington, DC: 1990), 1.

288. P. Marcotte, "Crime and Pregnancy," *American Bar Association Journal* (August 1989), 14.

289. For cases considering these provisions, see *State v. Bauer* (1991), 471 N.W. 2d 363 (upholding constitutionality of feticide statute); *Lawrence v. State* (1991), 409 S.E. 2d 661; *People v. Kuchan* (1991), 579 N.E. 2d 1054; *People v. Ford* (1991), 581 N.E. 2d 1189 (upholding constitutionality).

290. See also Illinois Annotated Statutes, ch. 38, para. 9-1.2 (Smith-Hurd 1988); Iowa Code Annotated, s. 707.7 (West 1979); Michigan Comp. Laws Annotated, s. 750.322 (West 1968); Mississippi Code Annotated, s. 97-3-37 (1973); New Hampshire Revised Statutes Annotated, s. 585.143 (1986); Oklahoma Statutes Annotated, title 21, s. 713 (West 1983); Utah Code Annotated, s. 76-5-201 (1988); Washington Revised Code Annotated, s. 9A.32.060 (1988); Wisconsin Statutes Annotated, s. 940.04 (West 1982).

291. California Penal Code, s. 187 (West 1988).

292. New York Penal Law, s. 125.00 (McKinney 1987).

293. See E.L. Thompson, "The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawmakers," *Indiana Law Journal* 64 (1989): 357-74. See discussion *infra* of these cases.

294. Much of this material is collected in an excellent article considering the constitutionality of such statutes as well as their policy appropriateness; see J.M. Jordan III, "Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women," *Georgia Law Review* 22 (1988): 1103-65. Other statutory references are collected in American Bar Association, *Drug Exposed Infants and Their Families: Coordinating Responses of the Legal, Medical and Child Protection System* (Washington, DC: 1990), 73; K. Moss, "Substance Abuse During Pregnancy," *Harvard Women's Law Journal* 13 (1990): 278-99. Other

references were collected through newspaper reports and statute searches. It is not possible to be certain that all bills and statutes have been identified.

295. (1976), 355 A. 2d 647.

296. *Cruzan v. Director, Missouri Department of Health* (1990), 110 S. Ct. 2841.

297. Many articles have been written on the issue of advance directives. For a recent review of the various legislative provisions providing for advance directives, see F. Rouse, "Advance Directives: Where Are We Heading After *Cruzan*?" *Law, Medicine and Health Care* 18 (1990): 353-59; W.L. Schoen, "Conflict in the Parameters Defining Life and Death in Missouri Statutes," *American Journal of Law and Medicine* 16 (1990): 555-80. See also the Uniform Rights of the Terminally Ill Act, 1-18, 9A U.L.A. 456 (Supp. 1990).

298. California Health & Safety Code, s. 7188 (Supp. 1987). See also Alaska Statutes, s. 18.12.040(c) (1986); Connecticut General Statutes Annotated, s. 19a-574 (Supp. 1987); Delaware Code Annotated, title 16, s. 2503(d) (1983); Florida Statutes Annotated, s. 165.08 (Supp. 1986); Florida Statutes Annotated, s. 765.05 (Supp. 1986); Georgia Code Annotated, s. 31-32-3(b) (Supp. 1987); Georgia Code Annotated, s. 31-32-8(a)(1) (1985); Hawaii Revised Statutes, s. 327D-6 (Supp. 1986); Illinois Annotated Statutes, ch. 110 1/2, s. 703(c) (Supp. 1987); Iowa Code Annotated, s. 144A. 6.2, 7.3 (Supp. 1987); Kansas Statutes Annotated, s. 65-28, 103 (1985); Maryland Health-General Code Annotated, s. 605(2) (Supp. 1987); Mississippi Code Annotated, s. 41-41-107 (Supp. 1986); Montana Revised Statutes, s. 459.205 (Supp. 1987); Montana Code Annotated, s. 50-9-202(3) (1987); New Hampshire Revised Statutes Annotated, s. 137H: 14(1) (Supp. 1986); Nevada Revised Statutes, s. 449.610 (1985); Oklahoma Statutes Annotated, title 63, s. 3103 (Supp. 1987); South Carolina Code Annotated, s. 44-77-70 (Supp. 1986); Texas Revised Civil Statutes Annotated, art. 4590h, s. 3(d) (Vernon Supp. 1987); Utah Code Annotated, s. 75-2-1109 (Supp. 1987); Washington Revised Code Annotated, s. 70.122.030(1)(c) (Supp. 1987); Wisconsin Statutes Annotated, s. 154.03(2) (Supp. 1986); Wisconsin Statutes Annotated, s. 154.07(2) (Supp. 1986).

299. Alaska Statutes, s. 1812.040(c) (1986). See also Iowa Code Annotated, s. 144A 6.2, 7.3 (Supp. 1987); Montana Code Annotated, s. 50-9-202(3) (1987).

300. Florida Statutes Annotated, s. 765.08 (Supp. 1986); Iowa Code Annotated, s. 144A 7.3 (Supp. 1987); New Hampshire Revised Statutes Annotated, s. 137H: 14(1) (Supp. 1986).

301. Georgia Code Annotated, s. 31-32-11(a) (1985): "Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative." But see section 31-32-11(b): "Furthermore, nothing in this chapter shall be construed to condone, authorize, or approve abortion."

302. Kansas, Session of 1991, House Bill No. 2089, s. 1(a).

303. An act concerning crimes and punishments; relating to conditions of probation, Kansas, Session of 1991, House Bill 2255, s. 3(d).

304. As reported in the *Globe and Mail* (6 August 1991): A7.

305. Illinois Juvenile Court Act, Ill. Rev. Stat. (1989) ch. 37, para. 802-3, s. 2-3(1)(c). See also District of Columbia, D.C. Code, s. 2-1352 (Supp. 1990), D.C.

Code, s. 16-2301; Hawaii, Hawaii Revised Statutes, s. 587-2 (1985); Hawaii Revised Statutes, s. 350-1(3) (1985); Massachusetts General Laws Annotated, ch. 119, s. 51A (West Supp. 1988).

306. Illinois Revised Statutes, ch. 37, 802-3(c) (1989).

307. House Bill 2835, 86th General Assembly, State of Illinois (1989 and 1990), amending ch. 38, new s. 12-4.7 (LRB8607533RCm6).

308. *Ibid.*

309. Indiana Code Annotated, s. 31-6-4-3.1 (Burns 1987).

310. Nevada Revised Statutes Annotated, s. 432 B.330 (Michie 1989).

311. Florida Statutes Annotated, s. 415.503(8) (West 1989).

312. Oklahoma Statutes Annotated, title 10, s. 1101 (West 1989).

313. "A person mandated to report ... shall immediately report to the local welfare agency, if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy."

314. Minnesota Statutes, s. 626.556 (1988).

315. *Ibid.*, s. 626.5562.

316. Oklahoma Statutes Annotated, title 21, s. 846 (West 1989).

317. Utah Code Annotated, s. 62A-4-504 (1989).

318. An Act to amend section 11165 of the Penal Code, relating to crimes. Senate Bill, no. 1070, as amended 20 April 1987.

319. Reported in *Reproductive Rights Update II* (13)(1990): 6.

320. 1989 Rhode Island Public Laws 252.

321. Florida Statutes Annotated, s. 415.503(8)(a)(2) (1986 & Supplement 1989).

322. 1989 Washington Legislation Service 271 (West).

323. State of New York, 9286-C. in Assembly, 8 February 1990; 7791-C, in Senate, 27 March 1990.

324. Congressional Caucus for Women's Issues, the Women's Health Equity Act of 1991, House bill introduced by Reps. Patricia Schroeder and Olympia Snowe; Senate bill introduced by Sen. Barbara Mikulski, February 1991, Washington, DC (draft bills only).

325. *Supra*, note 151.

326. *Ibid.*, 2.

327. California Medical Association, as quoted in *Johnson v. State* (1991), 578 So. 2d 419 at 426.

328. Report 00, House of Delegates of the American Medical Association, June 1990. Reported in American Medical Association, "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *JAMA* 264 (1990): 2663-70.

329. Ibid., 2665.
330. Ibid.
331. Ibid., 2666.
332. Ibid., 2667.
333. American Medical Association, *Drug Abuse in the United States: A Policy Report*, in *Proceedings of the House of Delegates*, 137th Annual Meeting of the Board of Trustees of the AMA, June 1988.
334. *Supra*, note 328, 2668.
335. Ibid.
336. Ibid.
337. Ibid.
338. Ibid., 2669.
339. Ibid., 2670.
340. "The AAP is concerned that such involuntary measures may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment." American Academy of Pediatrics, Committee on Substance Abuse, "Drug-Exposed Infants," *Pediatrics* 86 (1990): 639-42.
341. American Civil Liberties Union, *Reproductive Rights Update II* (6) (2 February 1990).
342. *Reproductive Rights Update III* (3) (5 April 1991).
343. *Re President & Directors of Georgetown College, Inc.* (1964), 331 F. 2d 1000.
344. *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson* (1964), 201 A. 2d 537; *Re Jamaica Hospital* (1985), 491 N.Y.S. 2d 898; *Crouse Irving Memorial Hospital, Inc. v. Paddock* (1985), 485 N.Y.S. 2d 443.
345. *Jefferson v. Griffin Spalding County Hospital Authority* (1981), 274 S.E. 2d 457.
346. *Re Madyun* (1990), 573 A. 2d 1259.
347. *Jefferson, supra*, note 345.
348. *Taft v. Taft* (1983), 446 N.E. 2d 395 (vacating order that the procedure be imposed as violating constitutional privacy rights).
349. (1987), 533 A. 2d 611; (1990) 573 A. 2d 1235.
350. Ibid., 1247.
351. *City Bank Farmers Trust Co. v. McGowan* (1945), 323 U.S. 594 as cited in *Re A.C.* at 1249.
352. *Re A.C., op. cit.*, 1250.
353. Ibid., 1252. "Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarian section, against that person's will."
354. *Reproductive Rights Update II* (1) (7 December 1990).

355. *Supra*, note 345.

356. *Reproductive Rights Update II* (7) (21 December 1990). See also *Reproductive Rights Update II* (7) (16 February 1990) reporting a court application to transfer Ms. Tawanda Walters from a hospital in Rockville, Maryland, to one in Baltimore. Ms. Walters declined to be transferred because she had a 19-month-old son and wanted to return home to care for him. The Circuit Court, Montgomery County, granted custody of Ms. Walters to the hospital and forced the transfer. The court held that although Ms. Walters is an "adult capable of decision-making, compelling public interests concerning protection of her unborn child entitle the court to enter an order under these circumstances."

357. V.E.B. Kolder, J. Gallagher, and M.T. Parsons, "Court-Ordered Obstetrical Interventions," *New England Journal of Medicine* 316 (1987): 1192-96. See also Dawson, *supra*, note 1.

358. *California v. Stewart*, Civ. No. 575396 (Mun. Ct Calif., San Diego County, 1987). The charges were dismissed because Ms. Stewart had been charged under an inappropriate statute. See D.E. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," *Harvard Law Review* 104 (1991): 1419-82; Moss, *supra*, note 294; Manson and Marolt, *supra*, note 284; "Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of 'Fetal Abuse,'" *Harvard Law Review* 101 (1988): 994-1012; B.I. Robin-Vergeer, "The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention," *Stanford Law Review* 42 (1990): 745-809.

359. California Penal Code, s. 270 (West 1988), "If a parent of a minor child wilfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanour punishable by a fine ... or by imprisonment ... not exceeding one year ... a child conceived but not yet born is to be deemed an existing person insofar as this section is concerned."

360. *Memorandum of Points and Authorities in Opposition to Defendant's Demurrer and Motion to Dismiss* (on file with author), p. 26.

361. *Supra*, note 327.

362. See Thompson, *supra*, note 293.

363. See *supra*, section entitled "Prenatal Abuse Provisions."

364. *Jennifer Johnson v. State*, *supra*, note 327. Ms. Johnson was convicted of delivery of drugs to a minor for delivery of a derivative of cocaine through the umbilical cord before the cord was cut. She was sentenced to 15 years, 1 under supervised custody in the community and 14 on probation. The conviction is under appeal on several legal grounds. See Moss, *supra*, note 294. But see *contra State v. Gethers* holding that the state misconstrued the effect of the statute and that such construction "would seem to be at odds with what appears to be the public policy of the state regarding child abuse and neglect ... to 'preserve the family life of the parent and children, to the maximum extent possible, by enhancing the parental capacity for adequate child care.'" (1991), 585 So. 2d 1140 at 1142.

365. Moss, *op. cit.*, 284.

366. See, for example, *Florida v. Jennifer Clarise Johnson*, Seminole Cty., Florida, E 89-890-CFA, "I am convinced and find that the term 'delivery' includes the

passage of cocaine or a derivative of it from the body of her child through the umbilical cord after birth occurs. The fact that the defendant was addicted to cocaine at the time of these offenses is not a defense. The choice to use or not use cocaine is just that — a choice."

367. *Michigan v. Kimberly Hardy*, 469 N.N. 2d So (Mich. App. 1991); see also *State v. Gethers*, *supra*, note 364.

368. *Ibid.*, per Murphy, J. at 52.

369. *Reproductive Rights Reporter II* (5) (26 October 1990).

370. *Wyoming v. Pfannenstiel*, No. 1-90-8CR (Laramire County Ct. complaint filed 5 January 1990) (unreported).

371. *Reproductive Rights Reporter II* (8) (20 July 1990). See also *Reproductive Rights Reporter II* (6) (2 February 1990).

372. *Re Steven S.* (1981), 126 Cal. App. 3d 525; *Re Dittrick* (1977), 263 N.W. 2d 37; *State v. Gethers*, *supra*, note 364.

373. *In re Valerle D.* (1991), 595 A. 2d 922 at 925 held that "a petition for neglect or termination of parental rights can be based solely on a mother's prenatal conduct." The conduct was cocaine ingestion prior to delivery.

374. See *Re Baby X* (1980), 293 N.W. 2d 736; *Re Ruiz* (1986), 500 N.E. 2d 935; *Re Troy D.* (1989), 263 Cal. Rptr. 869 at 874, "We agree that prenatal use of dangerous drugs by a mother is probative of future child neglect"; *Re Stefanal Tyesha C.* (1990), 556 N.Y.S. 2d 280 at 282, "the petitions sufficiently alleged causes of action for neglect based on the mothers' admitted use of drugs during their pregnancies, the children's positive toxicology for cocaine at birth and the failure of the mothers to be enrolled in a drug rehabilitation program at the time the petitions were filed"; *Re Stephen W.* (1990), 271 Cal. Rptr. 319.

375. *Re Milland* (1989), 548 N.Y.S. 2d 995 at 998, "The use of drugs or alcohol or cigarettes during pregnancy does not in and of itself establish an inability to properly care for and supervise the child that is born"; *Re Fletcher* (1988), 533 N.Y.S. 2d 241 at 243, "Without more, Petitioner's cause of action stands solely on a woman's pre-natal conduct. Does Petitioner argue that the mere use of a controlled substance any time in a parent's life proves inability to parent? What if the use occurred years before the child's birth or while a child is away at camp? If Petitioner suggests that any illicit drug use during a mother's lifetime adumbrates danger to her child, that argument must be rejected. It is the Commissioner's burden to prove that any prior drug use puts the child in danger now."

376. *Re Fletcher*, *op. cit.*, 243.

377. *Roberts, supra*, note 358, 1421, n. 6.

378. *Ibid.*, 1422, 1432.

379. *Ibid.*, 1433; I.J. Chasnoff, H.J. Landress, and M.E. Barrett, "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," *New England Journal of Medicine* 322 (1990): 1202-1206.

380. *Ibid.* Professor Roberts argues persuasively that the prosecution of women of colour diverts public attention from the implications of and responsibility for poverty, racism, and lack of a national health care policy and serves to degrade

women whom society sees as undeserving to be mothers and to be discouraged from having children. *Ibid.*, 1435-36.

381. *Ibid.*, 1423: "examining legal issues from the viewpoint of those whom they affect most helps to uncover the real reasons for state action and to explain the real harms that it causes. It exposes the way in which the prosecutions deny poor black women a facet of their humanity by punishing their reproductive choices."

382. *United States v. Vaughn*, Crim. No. F 2172-88 (D.C. Super. Ct. Aug. 23, 1988); see also *Cox v. Court* (1988), 537 N.E. 2d 721.

383. Quoted in D.C. Moss, "Pregnant? Go Directly to Jail," *American Bar Association Journal* (1 November 1988): 20.

384. S. Stefan, "Whose Egg Is It Anyway? Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women," *Nova Law Review* 13 (1989), 441; K.E. Holt, "Nine Months to Life — The Law and the Pregnant Inmate," *Journal of Family Law* 20 (1981-82), 527; G.A. McHugh, "Protection of the Rights of Pregnant Women in Prisons and Detention Facilities," *New England Journal of Prison Law* 6 (1980), 233.

385. Stefan, *op. cit.*, 441.

386. *Yeager v. Smith*, No. CV-F-87-493 (E.D.Cal.) (2 September 1987); *Jones v. Dyer*, No. H-114154-O (Sup. Ct. Alameda Cty., Ca.) (25 February 1986); *Harris v. McCarthy*, No. 8506002 WMB (C.D.Ca.) (11 September 1985).

387. "Incarcerating pregnant women to prevent them from having access to drugs 'shows an incredible naivete about the availability of drugs in jails and prisons.'" Ellen Barry, Director, Legal Services for Prisoners with Children, quoted in Stefan, *supra*, note 384, 443, n. 178.

388. *Reproductive Rights Reporter II* (3) (21 November 1990).

389. *Reproductive Rights Reporter III* (3) (25 January 1991); "Judge Is Firm on Forced Contraception," *New York Times (National)* (11 January 1991): A12.

390. Ohio Senate Bill No. 324 s. 2919.221(B)(2)(c); s. 2919.221(E).

391. *Re Lynda McCranie*, No. DI-88-104 Montana (Mont. 13th Jud. Dist. Ct., Yellowstone Cty.) (July 1988) (unreported); *Re Amie M.* (1986), 225 Cal. Rptr. 645; *Re M.M.* (1984), 485 A. 2d 180.

392. (1985), 497 A. 2d 1298.

393. *Ibid.*, 1309.

394. For an excellent article describing these cases and the constitutional implications thereof, see Jordan, *supra*, note 294.

395. L.M. Hill, D. Parker, and B.P. O'Neill, "Management of Maternal Vegetative State During Pregnancy," *Mayo Clinic Proceedings* 60 (1985): 469-72.

396. W.P. Dillon et al., "Life Support and Maternal Brain Death During Pregnancy," *JAMA* 248 (1982): 1089-91.

397. A. Reid, "Daughter Born to Woman in a Coma," *New York Times* (17 March 1985): 46.

398. "No Time Limit on Maintaining 'Dead' Mother to Save Fetus?" *Medical World News* (9 May 1983): 21.

399. Dillon et al., *supra*, note 396.
400. Civil Action No. 322 (C.P. Chester County, Pa.) (25 August 1982) (unreported).
401. (1984), 684 P. 2d 1297.
402. Civil Action File No. CV86-RCCV-464, Richmond Cty., Georgia at p. 4 (unreported).
403. *Re Klein* (1989), 538 N.Y.S. 2d 274 at 276.
404. See *Re A.C.*, *supra*, note 349.
405. *Supra*, note 268.
406. These policies took several forms, including limiting the number of hours or days of work for women, requiring rest periods, and prohibiting the employment of women in certain industries and occupations. See J.A. Baer, *The Chains of Protection: The Judicial Response to Women's Labor Legislation* (Westport: Greenwood Press, 1978); K.K. Sklar, "Hull House in the 1890's: A Community of Women Reformers," *Signs* 10 (1985): 658-77.
407. M.E. Becker, "From *Muller v. Oregon* to Fetal Vulnerability Policies," *University of Chicago Law Review* 53 (1986): 1219-73.
408. Cited in Becker, *op. cit.*, 1224. She also quotes the conclusion of the New York Factory Investigative Commission that "only a few of the women seemed to realize that this combination (of night work and family responsibilities) might prove disastrous ... Ignorant women can scarcely be expected to realize the dangers not only to their own health but to that of the next generation from such inhuman usage."
409. "Each of the troubling aspects of sex-specific protectionist legislation recurs in the contemporary debate over fetal vulnerability policies: the refusal to consider the effects of policies on women, the identification of women with (and only with) reproductive functions, the willingness to limit women's employment opportunities without evidence that women's employment poses real risks to others, the exclusion only of women perceived as marginal workers and the assumption that women are not competent decision makers." *Ibid.*, 1229.
410. See W. Chavkin, ed., *Double Exposure* (New York: Monthly Review Press, 1984); J.M. Stellman, *Women's Work, Women's Health* (New York: Pantheon Books, 1983); H.A. Furnish, "Prenatal Exposure to Fatally Toxic Work Environments: The Dilemma of the 1978 Pregnancy Amendment to Title VII of the Civil Rights Act of 1964," *Iowa Law Review* 66 (1980): 63-129; W.W. Williams, "Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII," *Georgetown Law Journal* 69 (1981): 641-704; N.A. Ashford and C.C. Caldart, "The Control of Reproductive Hazards in the Workplace: A Prescription for Prevention," *Industrial Relations Law Journal* 5 (1983): 523-63; A.E. Accurso, "Title VII and Exclusionary Employment Practices: Fertile and Pregnant Women Need Not Apply," *Rutgers Law Journal* 17 (1985): 95-134; Y. Sor, "Fertility or Unemployment — Should You Have to Choose?" *Journal of Law and Health* 1 (1986-87): 141-228; J.F. Katz, "Hazardous Working Conditions and Fetal Protection Policies: Women Are Going Back to the Future," *Boston College Environmental Affairs Law Review* 17 (1989): 201-30; L.A. Berkoff, "Protective Exclusion in the VDT Workplace: Why Alternatives Are Needed," *Hofstra Labor Law Journal* 6 (1989): 281-314; H.H. Kay, "Equality and Difference: The Case of

Pregnancy," *Berkeley Women's Law Journal* 1 (1985); S.J. Kenney, "Reproductive Hazards in the Workplace: The Law and Sexual Difference," *International Journal of the Sociology of Law* 14 (1986): 393-414; D. Hoadley, "Fetal Protection Policies — Effective Tools for Gender Discrimination," *Journal of Legal Medicine* 12 (1991): 85-104; L.M. Finley, "The Exclusion of Fertile Women from the Hazardous Workplace: The Latest Example of Discriminatory Protective Policies, or a Legitimate, Neutral Response to an Emerging Social Problem?" in *Proceedings of New York University 38th Annual National Conference on Labor*, ed. R. Adelman (New York: Matthew Bender, 1985), 16.01; Becker, *supra*, note 407.

411. Professor Becker lists the following major corporations: Olin, American Cyanamid, Allied Chemical, B.F. Goodrich, Monsanto, Sun Oil, Gulf Oil, Union Carbide, General Motors, Delco-Remy, St. Joe's Minerals, Bunker Hill, ASARCO. See Becker, *supra*, note 407, 1226.

412. See the description of these events found in U.S. Congress, Office of Technology Assessment, *Reproductive Health Hazards in the Workplace*, *supra*, note 86, 184. "The chronology of events suggests that the company initiated its exclusionary policy with little scientific justification and little sensitivity to the needs of its workers." *Ibid.*, 251. The Associated Press reported that one Canadian woman underwent a sterilization procedure to keep her job at a General Motors battery plant in Oshawa, Ontario. *Detroit Free Press*, 15 April 1979, p. B4.

413. O.T.A. Report, *op. cit.*, 255. See also Becker, *supra*, note 407, 1227, n. 40.

414. *Ibid.*

415. *Ibid.*, 253.

416. Professor Williams argues that: "Indeed, the problems of proving causation are so great that professed employer concern about liability may be a pretext for sex discrimination." Williams, *supra*, note 410, 646. Others are equally sceptical.

417. Finley, *supra*, note 410, 16.39. "An employer should not be able to let fears about highly uncertain, and insurable, potential tort liability justify discriminating against women by singling them out for exclusion from work environments that pose dangers to both sexes." *Ibid.*, 16.40.

418. O.T.A. Report, *supra*, note 412, 3.

419. 42 U.S.C. s. 2000e-2(a)(1) (1982).

420. *MacDonnell Douglas Corporation v. Green* (1973), 411 U.S. 792.

421. *Dothard v. Rawlinson* (1977), 433 U.S. 334.

422. *Harris v. Pan Am World Airways, Inc.* (1980), 649 F. 2d 670 at 676.

423. See *supra*, the discussion of the earlier decision of the Supreme Court of Canada to the same effect.

424. *Nashville Gas Co. v. Satty* (1977), 434 U.S. 136.

425. (1982) 42 U.S.C. s. 2000e (k).

426. (1982), 697 F. 2d 1172.

427. *Ibid.*, 1182. "None of these witnesses was qualified or testified as an expert in any relevant scientific or medical field."

428. *Ibid.*, 1190-91.

429. *Hayes v. Shelby Memorial Hospital* (1984), 726 F. 2d 1543.

430. *Ibid.*, 1548.

431. Bureau of National Affairs, "Equal Employment Opportunity Commission (EEOC) Withholds Approval of Broad Fetal Protection Plans, Agency Rulings: New Decisions, Orders, Regulations, Administrative Interpretations," *United States Law Week* 2461 (13 February 1990): 58.

432. Civil Rights Act of 1990, S.2104, 101st Congress, 2d Sess. (1990).

433. *Ibid.*, s. 4(k)(2).

434. *Ibid.*, s. 4(k)(1)(A).

435. *Ibid.*, s. 3(o).

436. *Johnson Controls*, *supra*, note 268, 173-74.

437. *Ibid.*, 175.

438. *Ibid.*, 178.

439. *Ibid.*, 179.

440. *Ibid.*, 181.

441. One thinks here of the language of Madame Justice Bertha Wilson with regard to the decision to continue a pregnancy in the *Morgentaler* case. *Supra*, note 11. As it is appropriate for the woman herself to determine the appropriateness of a pregnancy, it is equally so for her to determine the parameters within which she accepts and continues employment.

442. This proposition was accepted by the Supreme Court of Canada in *Montreal Tramways v. Léveillé* ([1933] S.C.R. 145), allowing an action against the tram company for injuries to the plaintiff's mother while the plaintiff was *in utero*, upon the subsequent live birth of plaintiff. *Montreal Tramways* was followed by American courts. See *Bonbrest v. Kotz* (1946), 65 F. Supp. 138.

443. For authors who argue for expansion of maternal liability, see P.A. King, "The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn," *Michigan Law Review* 77 (1979): 1647-87; J.A. Parness and S.K. Pritchard, "To Be or Not to Be: Protecting the Unborn's Potentiality of Life," *University of Cincinnati Law Review* 51 (1982): 257-98; M.W. Shaw, "Conditional Prospective Rights of the Fetus," *Journal of Legal Medicine* 5 (1984): 63-116; J.A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth," *Virginia Law Review* 69 (1983): 405-64; B.I. Chernaik, "Recovery for Prenatal Injuries: The Right of a Child Against Its Mother," *Suffolk University Law Review* (1976): 582-609. In Canada, see Keyserlingk, *supra*, note 174.

444. (1981), 301 N.W. 2d 869.

445. *Ibid.*, 870-71.

446. (1988), 531 N.E. 2d 355.

447. *Ibid.*, 358.

448. *Ibid.*

449. See R. Beal, "Can I Sue Mommy? An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive," *San Diego Law Review* 21 (1984): 325-70.

450. "As clients, women's needs arise from their disfavoured structural position in society. As social welfare clients, they have control neither over the definition of their own problems nor over scarce resources that might respond to their needs." B. Heppner and L. Davies, *Analysis of the Division of Labour and the Labour Force in Social Service Structures in Québec: Towards a New Definition of Professionalism*, study prepared for Commission d'enquête sur les services de santé et les services sociaux (Quebec: Publications Québec, 1986). See also C. Colin and H. Desrosiers, *Naitre égaux et en santé* (Quebec: Ministère de la Santé et des Services sociaux, 1989).

451. See "Welfare Experts Sound Alarm," *Globe and Mail* (6 August 1991). "Child protection agencies in Toronto and in Montreal's anglophone community are becoming involved with black families far out of proportion to the number of blacks living in these cities, startling new statistics show ... But the black communities and the established agencies, though they are working increasingly together, are at odds over why a disproportionate number of black families are being monitored ... the black community argues that mainline agencies do not understand cultural differences in black families, are quicker to become involved, more harshly judgmental and unable to provide effective help"; Monture, *supra*, note 193. A disproportionate number of Aboriginal children are in care. In 1980, 6 percent of First Nations children were in care, compared to 1 percent of children from non-Aboriginal families. See Manitoba, Public Inquiry into the Administration of Justice and Aboriginal People, *Report of the Aboriginal Justice Inquiry of Manitoba, Volume I: The Justice System and Aboriginal People* (Winnipeg: The Inquiry, 1991), chap. 13, for a discussion of Aboriginal women and the Canadian justice system. D. Avard and L. Hanvey, *The Health of Canada's Children: A CICH Profile* (Ottawa: Canadian Institute of Child Health, 1989), 115. Other women whose disadvantage is compounded, including lesbians, the physically challenged, women who are HIV positive, and women of colour, probably show similar patterns of state interference. Unfortunately, there is little documentation of the interaction of the state with women from these communities in Canada.

452. In 1986, the general Canadian rate for infant mortality was 7.9 per 1 000 compared to 17.5 per 1 000 for Indian infants. E. Bobet, *Inequalities in Health: A Comparison of Indian and Canadian Mortality Trends* (Ottawa: Health and Welfare Canada, 1990).

453. E. Bobet and C. McBride, "Health of Indian Women," working paper (Ottawa: Indian Affairs and Northern Development Canada, 1991).

454. Dwellings without central heating on reserve, 38 percent; off reserve, 9 percent; in the general population, 5 percent. Crowded dwellings (more than one person per room) on reserve, 28.9 percent; off reserve, 11.3 percent; general population, 1.8 percent. There has also been a lower rate of running water and poorer sewage systems and other services for Natives than for the general population. Bobet and McBride, *op. cit.*

455. On reserve, male \$10 362, female, \$7 756; off reserve, male \$13 649, female \$8 848; Canadians, male \$23 265, female \$12 615. *Ibid.* See also Canada, Statistics Canada, "Birth by Income," *Health Reports* 3 (1)(1991); "Births 1987-1988," *Health Reports* 2 (1)(1990).

456. C. Farkas et al., "Explanatory Models of Health During Pregnancy: Native Women and Non-Native Health Care Providers in Toronto," *Native Studies Review* 5 (1989): 79-95.
457. D.C. Speck, "The Indian Health Transfer Policy: A Step in the Right Direction, or Revenge of the Hidden Agenda?" *Native Studies Review* 5 (1989), 188 and sources cited therein.
458. "Health" has traditionally been conceptualized by First Nations as an integral part of all aspects of life and as a reflection of individual and collective relationships to the natural, social and spiritual environment. Speck, *op. cit.*, 189. See also M. Pilon, *Les Enjeux socio-sanitaires au Québec: Les besoins de la population* (Quebec: 1987), 24-26.
459. *Supra*, note 1.
460. But see G. Koren, ed., *Maternal-Fetal Toxicology: A Clinician's Guide* (New York: Marcel Dekker, 1990), 146: "The lifestyle of intravenous drug-using women plays a very important part in the formulation of the treatment plan. If the woman and her children remain in the drug-using community, she is not likely to abstain. Furthermore, pregnancy does not protect her from the high incidence of physical violence these women experience."
461. C.B. McCullough, "The Child Welfare Response," *The Future of Children* 1 (1991): 61-71.
462. See, on the use of medical expertise, *Ackerman v. McGoldrick*, *supra*, note 1; Ehrenreich and English, *supra*, note 236.
463. "No longer should health (social) problems be seen as individual risk consequences requiring individual behavioural change. Instead, health and its obverse, disease, should be understood as complex, highly conditioned social phenomena which demand social change through collective forms of action." R. Labonté and S. Penjold, "Canadian Perspective in Health Promotion: A Critique," *Health Education* 10 (1981): 4-9; "Without that awareness, the familiar syndrome of 'blaming the victim' takes precedence: responsibility for her situation is assigned wholly to the individual. By logical extension, this assignment of responsibility and concomitant lack of self-reliance then proves that in some manner she chose her situation. And by further extension, without professional intervention designed to force, cajole, lead or 'change' the symptoms of such passively self-destructive individuals they will continue willfully to choose disease over wellness, poverty over a comfortable life. The individual client thus ends up the thinly disguised villain of the social service structure, behaving contrary to 'human nature' and plainly irresponsibly. By implication, our unequal society, with its sexual asymmetry, is the natural, good one and is not accountable for its part in individuals' situations." Heppner and Davies, *supra*, note 450, 37-38.
464. I do not use the term "disadvantaged" for the reasons referred to by P.A. Monture, "The Voices of Aboriginal People," in *Creating Choices: The Report of the Task Force on Federally Sentenced Women* (Ottawa: Correctional Service Canada, 1990). "Firstly, the disadvantage here discussed is primarily an economic disadvantage which then impacts negatively on the women's social experience and quality of life. Secondly, being labelled disadvantaged is often oppressive in and of itself. Such labelling conflicts with a definition of true equality (that is the respect

and celebration of difference). Disadvantage when measured only by a material yardstick leads to this negative labelling." *Ibid.*, 16, note 6.

465. "The use of punishment, rather than treatment, as a first resort speaks unmistakably about the state's motive." L. Gostin, "Waging a War on Drug Abusers: An Alternative Public Health Vision," *Law, Medicine and Health Care* 18 (1990), 388.

466. H.M. Cole, "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *JAMA* 264 (1990), 2669.

467. Center for the Future of Children, "Drug Exposed Infants," *Future of Children* 1 (1991), 9; "If the consequences of confiding in a health care provider or social worker include denial of governmental benefits, removal of parental rights, or even loss of liberty, drug dependent people will be less likely to trust the treatment system." *Gostin, supra*, note 465, 391.

468. See "Cocaine and Pregnancy," *Ottawa Citizen* (10 August 1991): E12; "One study of babies exposed to opiates showed that the quality of the home environment, and not the amount of substances taken by the mother while pregnant, was a more important determinant of outcome. Thus, biologic vulnerability created by exposure to substances *in utero* can be highly modified or exacerbated by social factors," B. Zuckerman, "Drug-Exposed Infants: Understanding the Medical Risk," *Future of Children* 1 (1991), 34.

469. D. Kronstadt, "Complex Developmental Issues of Prenatal Drug Exposure," *Future of Children* 1 (1991), 44. "Based on studies of those mothers identified as substance-abusing (which ... may not fairly represent all substance-abusing mothers), many are from families with an intergenerational legacy of chemical dependence and physical, sexual, and/or emotional abuse." *Ibid.*

470. *Ibid.*, 45.

471. McCullough, *supra*, note 461, 69; Gostin, *supra*, note 465, "The in-vogue policies of user accountability and zero tolerance make it acceptable to direct the state's formidable powers at drug dependent persons themselves. Drug dependent persons have profound physical and psychological problems, and are primarily concentrated in poor, minority urban areas. As a group, seriously drug dependent people are most vulnerable to the abuse of state power and least able to obtain needed health care services."

472. K.L. Kumpfer, "Treatment Programs for Drug-Abusing Women," *Future of Children* 1 (1991), 55.

473. For a rare exception, see T.H. Murray, "Prenatal Drug Exposure: Ethical Issues," *Future of Children* 1 (1991), 107: "Men also have moral obligations to their children and to their not-yet-born children ... If drinking or taking drugs leads him to become violent or encourages the pregnant woman to use the same, he bears moral culpability for his actions. A father-to-be can be equally or more at fault for not insuring that the not-yet-born child gets adequate prenatal care by refusing to pay for it or by other such behaviors." While this statement suggests an appropriate focus on male responsibility, to the extent that it suggests that the male should be a dependable economic source or that male partners should ensure 'moral' behaviour by women, its views are stereotypical.

474. "The TOPS (Treatment Outcome Perspective Study) measured significant declines in drug treatment use in all treatment modalities, and the effects were enduring." Gostin, *supra*, note 465, 389.
475. W. Chavkin, "Drug Addiction and Pregnancy: Policy Crossroads," *American Journal of Public Health* 4 (1990): 483-87.
476. Cited in Kumpfer, *supra*, note 472.
477. Canada, *Action on Drug Abuse: Making a Difference* (Ottawa: Minister of Supply and Services Canada, 1988), 7.
478. *Ibid.*, 25 seq.
479. Kumpfer, *supra*, note 472, 53 seq.; E. Thomas, *Issues and Priorities for Women's Health in Canada: A Key Informant Study* (Ottawa: Health and Welfare Canada, 1986); F.L. Paltiel, "State Initiatives — Impetus and Effects," paper delivered at the conference "Women and the Canadian State," University of Ottawa, November 1990; K. Messing, *Occupational Safety and Health Concerns of Canadian Women* (Ottawa: Labour Canada, 1991).
480. See also E. Adelberg and C. Laprairie, *Programs Branch User Report, A Canadian Directory of Programs and Services for Women in Conflict with the Law* (Ottawa: Solicitor General Canada, 1985).
481. Inter-American Commission on Drug Policy, *Setting Opportunities* (San Diego: University of California, Institute of the Americas and the Center for Iberian and Latin American Studies, 1991); "It makes no sense to threaten prosecution of a pregnant woman to encourage drug treatment if there are no treatment facilities available to her. Furthermore, incarcerating a pregnant woman either in jail or in a treatment facility will require those facilities to provide prenatal care and care for newborns and possibly siblings — something which few currently offer." Center for the Future of Children, *supra*, note 467, 15.
482. *Ibid.*, 11.
483. *Ibid.*, 15.
484. *Ibid.*, 24. "There are virtually no drug treatment programs for one of the most vulnerable groups of all, poor women with children." *Ibid.*, 25.
485. A punitive approach "presumes that these women can and will 'control' their behavior in response to threats. Yet, the pregnant woman who uses drugs has already demonstrated that she is not deterred by threats; her use of illegal drugs in and of itself carried the possibility of prosecution and imprisonment whether or not she was pregnant, and that possibility did not deter her. There is little reason to believe that an additional threat will be a more effective deterrent." *Ibid.*, 15.
486. Kumpfer, *supra*, note 472, 56.
487. See S.A. Smirnov, "Maternity Protection: National Law and Practice in Selected European Countries," *International Social Security Review* 32 (1979): 420.
488. *A.G. Queensland v. T* (1983), 57 Aust. L.J. Reports 285.
489. *Re Marriage of F* (1989), 13 Fam L.R. 189.
490. *Ibid.*
491. C. Paoli, "Women Workers and Maternity: Some Examples from Western Europe," *International Labour Review* 121 (1982), 5.

492. *Ibid.*
493. *Ibid.*, 6.
494. R. Blanpain, ed., *International Encyclopaedia for Labour Law and Industrial Relations* (Deventer: Kluwer, 1977), Vol. 2, Austria, 113.
495. Paoli, *supra*, note 491, 6.
496. Smirnov, *supra*, note 487, 433.
497. Paoli, *supra*, note 491, 5.
498. *Ibid.*
499. *Ibid.*, 6.
500. Smirnov, *supra*, note 487, 433.
501. *I.L.O. Social and Labour Bulletin* 3/88.
502. *I.L.O. Social and Labour Bulletin* 3/87.
503. Article 27, cited in H.J. Maroney and M. Luxton, eds., *Feminism and Political Economy: Women's Work, Women's Struggle* (Toronto: Methuen, 1987), 249.
504. Smirnov, *supra*, note 487, 433.
505. Maroney and Luxton, *supra*, note 503, 249.
506. Czech Protective Labour Code, cited in Maroney and Luxton, *op. cit.*, 250.
507. Smirnov, *supra*, note 487, 435.
508. *Ibid.*, 433.
509. R. Nielsen, "Special Protective Legislation for Women in the Nordic Countries," *International Labour Review* 119 (1980): 39-49.
510. *Paton v. Trustees of BPAS*, [1978] 2 All E.R. 987.
511. The Congenital Disabilities (Civil Liability) Act, 1976. This act ousted the common law, under which a potential or contingent duty of a care to the fetus crystallized on birth, enabling the child to maintain a cause of action. See *B. v. Islington Health Authority*, [1991] 1 All E.R. 825. Special provisions are contained in the act for damages resulting from nuclear radiation and from infertility treatments.
512. Congenital Disabilities Act, 1976: Liability of women driving while pregnant.
513. *McKay v. Essex Area Health Authority*, [1982] 2 All E.R. 771 (C.A.).
514. *Berkshire County Council v. D.*, [1987] 1 All E.R. 20 (House of Lords).
515. *In re F. (In utero)*, [1988] 2 W.L.R. 1288 (C.A.).
516. Paoli, *supra*, note 491, 6.
517. *Page v. Freight Hire (Tank Haulage) Ltd.*, [1981] 1 All E.R. 394.
518. *Hayes v. Malleable Men's Club*, [1985] Industrial Cases Reports 703 (Employment Appeal Tribunal); *Webb v. Emo Air Cargo (U.K.) Ltd.*, [1990] Industrial Cases Reports 443 (Employment Appeal Tribunal).
519. Employment Protection (Consolidation) Act, 1978, s. 60.
520. *Grimsby Carpet Co. Ltd. v. Bedford*, [1987] Industrial Cases Reports 975 (Employment Appeal Tribunal).

521. *Brown v. Stockton-on-Tees Borough Council*, [1988] Weekly Law Reports 935 (H.L.).
522. *Clayton v. Vigers*, [1989] Industrial Cases Reports 713 (Employment Appeal Tribunal).
523. Employment Act, 1989, section 9, cited in *I.L.O. Social and Labour Bulletin* 1/90.
524. *I.L.O. Social and Labour Bulletin* 3-4/85.
525. Nielsen, *supra*, note 509, 47.
526. M. Drapier, "La loi relative à l'interruption volontaire de grossesse dix ans après: histoire d'un compromis," *Revue du Droit public et de la Science politique* 101 (1985): 443.
527. Social Security Code, Book III [Social Insurance], Title II [Allowances], Chapter I [Prenatal Allowances], Art. L. 516 and 517.
528. Public Health Code, Book II [Health of the Family and of Infants], Chapter III [Protection of Future Parents], Art. L. 159. By Art. 7 of Decree 62-840 of 19 July 1962, the order of the Minister shall specify the nature and means of the examinations in order to discover any case of tuberculosis, syphilis, fetal-maternal blood incompatibilities, and any other condition apt to affect maternal or child health. If one of the visits is missed or not conducted according to the procedure set out by the Minister, a percentage of the prenatal allowances is withheld. However, such percentage may nevertheless be paid if the woman missed the visit by reason of "*force majeure*."
529. Decree No. 62-840, 19 July 1962, concerning maternal and child protection, Art. 7.
530. Ibid., Art. L. 162. Article 7-1 of Decree 62-840, 19 July 1962, provides that these visits may be made by midwives or by any other health or social services staff member of the maternal and child protection centre.
531. F. Dekeuwer-Defossez, *Droits des femmes: Dictionnaire juridique* (Paris: Dalloz, 1985), 229.
532. Code du travail, Art. L. 122-25.
533. Code du travail, Art. L. 122-25-2.
534. Cited in C. Sutter, "Du droit de la maternité au droit à la procréation," *Droit social* 11 (1981), 714.
535. Code du travail, Art. L. 122-25 and Art. L. 122-25-1.
536. Paoli, *supra*, note 491, 6.
537. Code du travail, Art. R. 234-4.
538. Code du travail, Art. R. 234-6.
539. Code du travail, Art. R. 241-50. In practice, this right is non-existent, given the conditions in which workplace medicine is practised.
540. M. Devaud and M. Levy, "Women's Employment in France: Protection or Equality?" *International Labour Review* 119 (1980), 746.
541. Decision of the Federal Constitutional Court of 25 February 1975, invalidating section 218a of the Abortion Reform Act.

542. Smirnov, *supra*, note 487, 433.
543. Paoli, *supra*, note 491, 5.
544. Ibid.
545. Ibid., 6.
546. Ibid.
547. Maternity Protection Act of 1979, cited in U.S. Congress, Office of Technology Assessment, *Reproductive Health Hazards in the Workplace*, Vol. 2 (Washington, DC: OTA, 1986), 39.
548. Smirnov, *supra*, note 487, 433.
549. E. Gomori, "Special Protective Legislation and Equality of Employment Opportunity for Women in Hungary," *International Labour Review* 119 (1980), 69.
550. Ibid., 71.
551. Smirnov, *supra*, note 487, 433.
552. Paoli, *supra*, note 491, 5.
553. Ibid.
554. Ibid., 6.
555. Ibid.
556. Personal communication from the Consul General of the Netherlands, 16 September 1991, on file with the author.
557. Smirnov, *supra*, note 487, 433.
558. Nielsen, *supra*, note 509, 47.
559. Smirnov, *supra*, note 487, 433.
560. Ibid.
561. M. Jimenez Butragueno, "Protective Legislation and Equal Opportunity and Treatment for Women in Spain," *International Labour Review* 121 (1982), 188.
562. Institut Suédois, "Feuillet de documentation sur la Suède: l'égalité entre l'homme et la femme," (Stockholm: Institut Suédois, October 1989), 3.
563. Ibid., 2.
564. Nielsen, *supra*, note 509, 47.
565. D. Bradley, "Sexual Equality and Maintenance Allowances in Sweden," *Oxford Journal of Legal Studies* (1989), 406, n. 26.
566. Institut Suédois, *supra*, note 562, 2.
567. R. Blanpain, ed., *International Encyclopaedia for Labour Law and Industrial Relations* (Deventer: Kluwer, 1977), Vol. 10, Switzerland, 76.
568. Ibid., 124-25.
569. This material represents information available prior to the change in political structures. It is unknown what will be kept or changed by the countries that were part of the USSR.

570. A.P. Biryukova, "Special Protective Legislation and Equality of Opportunity for Women Workers in the USSR," *International Labour Review* 119 (1990): 51-65. This material represents information available prior to the change in political structures.
571. Smirnov, *supra*, note 487, 433.
572. Biryukova, *supra*, note 570, 56.
573. *Ibid.*, 61.
574. *I.L.O. Social and Labour Bulletin* 2/85.
575. The Social Charter was signed 18 October 1961 and came into effect in February 1965.
576. [1991] I.R.L.R. 27.
577. *X. v. The United Kingdom* (1980), 19 Eur. Comm'n on Human Rights Decisions and Reports, at 244.
578. *Bruggemann and Scheutin v. The Federal Republic of Germany* (1978), 10 Eur. Comm'n on Human Rights Decisions and Reports, Vol. 10, 1978.
579. *Paton v. U.K.* (1981), 3 E.H.R.R. 408, cited in B.M. Knoppers, *Conception artificielle et responsabilité médicale* (Cowansville: Yvon Blais, 1986), 173.
580. *Reproductive Health Hazards in the Workplace*, *supra*, note 547, Vol. 2, 14.
581. *Ibid.*, Vol. 2, 20.
582. *I.L.O. Social and Labour Bulletin* 3/87.
583. Convention No. 3, in force 13 June 1921.
584. International Labour Organization, Convention concerning the Employment of Women before and after Childbirth (Convention 103), adopted 28 June 1952, in force 7 September 1955.
585. General Assembly resolution 2263 (XXII) of 7 November 1967.
586. General Assembly resolution 34/180 of 18 December 1979, in force 3 September 1981.

Bibliography

Books, Articles, Reports

- Accurso, A.E. "Title VII and Exclusionary Employment Practices: Fertile and Pregnant Women Need Not Apply." *Rutgers Law Journal* 17 (1985): 95-134.
- Adelberg, E., and C. Laprairie. *Programs Branch User Report. A Canadian Directory of Programs and Services for Women in Conflict with the Law*. Ottawa: Solicitor General Canada, 1985.
- American Academy of Pediatrics. Committee on Substance Abuse. "Drug-Exposed Infants." *Pediatrics* 86 (1990): 639-42.
- American Bar Association. *Drug Exposed Infants and Their Families: Coordinating Responses of the Legal, Medical and Child Protection System*. Washington, DC: ABA, 1990.

- American Civil Liberties Union. *Reproductive Rights Update*. Various issues.
- American College of Obstetricians and Gynecologists. Committee on Ethics. *Patient Choice: Maternal-Fetal Conflict*. Committee Opinion No. 55. Washington, DC: ACOG, 1987.
- American Conference of Governmental Industrial Hygienists. *Threshold Limit Values for Chemical Substances and Physical Agents and Biological Exposure Indices*. Cincinnati: ACGIH, 1990-1991.
- American Medical Association. *Drug Abuse in the United States: A Policy Report*. In *Proceedings of the House of Delegates*, 137th Annual Meeting of the Board of Trustees of the AMA, June 1988.
- . "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." Report 00 adopted at AMA Annual Meeting, June 1990. Reported in *JAMA* 264 (1990): 2663-70.
- Anand, R. "HIV Testing in the Unionized Workplace: The Accommodation Challenges Posed by AIDS." *Canadian Labour Law Journal* 1 (1992): 100-124.
- Armstrong, P., and H. Armstrong. *The Double Ghetto: Canadian Women and Their Segregated Work*. Toronto: McClelland and Stewart, 1978.
- Ashford, N.A., and C. Caldart. "The Control of Reproductive Hazards in the Workplace: A Prescription for Prevention." *Industrial Relations Law Journal* 5 (1983): 523-63.
- Avard, D., and L. Hanvey. *The Health of Canada's Children: A CICH Profile*. Ottawa: Canadian Institute of Child Health, 1989.
- Backhouse, C.B. "Desperate Women and Compassionate Courts: Infanticide in Nineteenth-Century Canada." *University of Toronto Law Journal* 34 (1984): 447-78.
- . "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada." *Windsor Yearbook of Access to Justice* 3 (1983): 61-130.
- Baer, J.A. *The Chains of Protection: The Judicial Response to Women's Labor Legislation*. Westport: Greenwood Press, 1978.
- Beal, R. "Can I Sue Mommy?" An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive." *San Diego Law Review* 21 (1984): 325-70.
- Becker, M.E. "From *Muller v. Oregon* to Fetal Vulnerability Policies." *University of Chicago Law Review* 53 (1986): 1219-73.
- Bélanger, S. "Le Retrait préventif de la travailleuse enceinte." *Canadian Journal of Women and the Law* 1 (1986): 498-504.
- Belton, R. "The Dismantling of the Griggs Disparate Impact Theory and the Future of Title VII: The Need for a Third Reconstruction." *Yale Law and Policy Review* 8 (1990): 223-56.
- Beral, V. "Leukaemia and Nuclear Installations: Occupational Exposure of Father to Radiation May Be the Explanation." *British Medical Journal* (17 February 1990): 411-12.
- Berkoff, L.A. "Protective Exclusion in the VDT Workplace: Why Alternatives Are Needed." *Hofstra Labor Law Journal* 6 (1989): 281-314.

- Bernstein, D. "A Contractual Solution to the Contraceptive Crisis." *Yale Law and Policy Review* 8 (1990): 146-62.
- Biryukova, A.P. "Special Protective Legislation and Equality of Opportunity for Women Workers in the USSR." *International Labour Review* 119 (1980): 51-65.
- Blanpain, R., ed. *International Encyclopaedia for Labour Law and Industrial Relations*. Deventer: Kluwer, 1977.
- Bobet, E. *Inequalities in Health: A Comparison of Indian and Canadian Mortality Trends*. Ottawa: Health and Welfare Canada, 1990.
- Bobet, E., and C. McBride. "Health of Indian Women." Working paper. Ottawa: Indian Affairs and Northern Development Canada, 1992.
- Boris, E. "The Power of Motherhood: Black and White Activist Women Redefine the Political." *Yale Journal of Law and Feminism* 2 (1989): 25-49.
- Boyle, C.L.M. *Sexual Assault*. Toronto: Carswell, 1984.
- Bradley, D. "Sexual Equality and Maintenance Allowances in Sweden." *Oxford Journal of Legal Studies* (1989): 403.
- Bureau of National Affairs. "Equal Employment Opportunity Commission (EEOC) Withholds Approval of Broad Fetal Protection Plans, Agency Rulings: New Decisions, Orders, Regulations, Administrative Interpretations." *United States Law Week* 2461 (13 February 1990): 58.
- Burton IV, C.R. "Fetal Drug or Alcohol Addiction Syndrome: A Case of Prenatal Child Abuse?" *Willamette Law Review* 25 (1989): 223-42.
- Cahalane, D.K. "Court-Ordered Confinement of Pregnant Women." *New England Journal on Criminal and Civil Confinement* 15 (1989): 203-23.
- Canada. *Action on Drug Abuse: Making a Difference*. Ottawa: Minister of Supply and Services Canada, 1988.
- Canada. Department of Justice. Committee on the Operation of the Abortion Law. *Report* Ottawa: Minister of Supply and Services Canada, 1977.
- Canada. Health and Welfare Canada. *The Pregnant Worker: A Resource Document for Health Professionals*. Ottawa: Federal-Provincial Advisory Committee on Environmental and Occupational Health, 1991.
- Canada. Labour Canada. Women's Bureau. *Canadian Women and Job Related Laws*. Ottawa: Women's Bureau, 1981.
- Canada. Royal Commission on Equality in Employment. *Report*. Ottawa: Minister of Supply and Services Canada, 1984.
- Canada. Statistics Canada. "Birth by Income." *Health Reports* 3 (1)(1991).
—. "Births 1987-1988." *Health Reports* 2 (1)(1990).
- Canadian Bar Association. *Submission of the CBA to the Royal Commission on New Reproductive Technologies*. Ottawa, 1990.
- Canadian Chemical Producers' Association. "Draft CCPA Guideline on Reproductive and Developmental Hazards in the Workplace." Ottawa: n.d.

- Canadian Medical Association. Committee on Ethics. *The Status of the Human Foetus*. Ottawa: CMA, 1991.
- Center for the Future of Children. "Drug Exposed Infants." *Future of Children* 1 (1991).
- Chasnoff, I.J., H.J. Landress, and M.E. Barrett. "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida." *New England Journal of Medicine* 322 (1990): 1202-1206.
- Chavkin, W., ed. *Double Exposure*. New York: Monthly Review Press, 1984.
- Chavkin, W. "Drug Addiction and Pregnancy: Policy Crossroads." *American Journal of Public Health* 80 (1990): 483-87.
- Chenier, N.M. *Reproductive Hazards at Work: Men, Women and the Fertility Gamble*. Ottawa: Canadian Advisory Council on the Status of Women, 1982.
- Chernaik, B.I. "Recovery for Prenatal Injuries: The Right of a Child Against Its Mother." *Suffolk University Law Review* 10 (1976): 582-609.
- Chunn, D.E. "Regulating the Poor in Ontario: From Police Courts to Family Courts." *Canadian Journal of Family Law* 6 (1987): 85-102.
- "Cocaine and Pregnancy." *Ottawa Citizen* (10 August 1991): E 12.
- Cole, H.M. "Legal Interventions During Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." *JAMA* 264 (1990): 2663-70.
- Colin, C., and H. Desrosiers. *Naître égaux et en santé*. Quebec: Ministère de la Santé et des Services sociaux, 1989.
- "Criminal Liability of a Prospective Mother for Prenatal Neglect of a Viable Fetus." *Whittier Law Review* 9 (1987): 363.
- Dawson, T.B. "Re Baby R: A Comment on Fetal Apprehension." *Canadian Journal of Women and the Law* 4 (1990): 265-75.
- Dekeuwer-Defosse, F. *Droits des femmes: dictionnaire juridique*. Paris: Dalloz, 1985.
- Deleury, É., and A. Cloutier. "The Child, the Family and the State: Seeking to Identify the Best Interests of the Child." *New Visions of Current Issues* (1987): 211.
- Devaud, M., and M. Levy. "Women's Employment in France: Protection or Equality?" *International Labour Review* 119 (1980): 739-54.
- Dillon, W.P., et al. "Life Support and Maternal Brain Death During Pregnancy." *JAMA* 248 (1982): 1089-91.
- Doern, G.B. *Regulatory Processes and Jurisdictional Issues in the Regulation of Hazardous Products in Canada*. Science Council of Canada Background Study No. 41. Ottawa: Minister of Supply and Services Canada, 1977.
- Dorczak, A. "Unborn Child Abuse: Contemplating Legal Solution." *Canadian Journal of Family Law* 9 (1991): 133-56.
- Drapier, M. "La Loi relative à l'interruption volontaire de grossesse dix ans après: histoire d'un compromis." *Revue du Droit public et de la Science politique* 101 (1985): 443.

- Dupras, A., and M. Lemay. "Contrôle de la fertilité et handicap mental: un bilan de la situation au Québec (1977-1981)." *Bulletin canadien de l'aide juridique* 4 (1981): 193-210.
- Ehrenreich, B., and D. English. *For Her Own Good: 150 Years of the Expert's Advice to Women*. New York: Anchor Press, 1978.
- Engles, W.R. "The 'Substantial Relation' Question in Gender Discrimination Cases." *University of Chicago Law Review* 52 (1985): 149-76.
- Farkas, C., et al. "Explanatory Models of Health During Pregnancy: Native Women and Non-Native Health Care Providers in Toronto." *Native Studies Review* 5 (1989): 79-95.
- Finley, L.M. "The Exclusion of Fertile Women from the Hazardous Workplace: The Latest Example of Discriminatory Protective Policies, or a Legitimate, Neutral Response to an Emerging Social Problem?" In *Proceedings of New York University 38th Annual National Conference on Labor*, ed. R. Adelman. New York: Matthew Bender, 1985.
- Furnish, H.A. "Prenatal Exposure to Fetally Toxic Work Environments: The Dilemma of the 1978 Pregnancy Amendment to Title VII of the Civil Rights Act of 1964." *Iowa Law Review* 66 (1980): 63-129.
- Gallagher, J. "Prenatal Invasions & Interventions: What's Wrong with Fetal Rights." *Harvard Women's Law Journal* 10 (1987): 9-58.
- Gavigan, S. "The Abortion Prohibition and the Liability of Women: Historical Development and Future Prospects." Thesis, York University, Osgoode Hall Law School, 1984.
- . "The Criminal Sanction as It Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion." *Journal of Legal History* 5 (1984): 20-43.
 - . "On 'Bringing on the Menses': The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law." *Canadian Journal of Women and the Law* 1 (1986): 279.
 - . "Women and Abortion Law in Canada: What's Law Got to Do with It?" In *Feminism and Political Economy*, ed. H.J. Maroney and M. Luxton. Toronto: Methuen, 1987.
- George Washington University. Intergovernmental Health Policy Project. *Key Battle in War on Drugs: Saving Pregnant Women, Endangered Babies*. State Health Notes. Washington, DC: 1990.
- Goldberg, S. "Medical Choices During Pregnancy: Whose Decision Is It Anyway?" *Rutgers Law Review* 41 (1989): 591-623.
- Gomori, E. "Special Protective Legislation and Equality of Employment Opportunity for Women in Hungary." *International Labour Review* 119 (1980): 67-75.
- Gostin, L. "Waging a War on Drug Users: An Alternative Public Health Vision." *Law, Medicine and Health Care* 18 (1990): 385-94.
- Grant, I. "Forced Obstetrical Intervention: A Charter Analysis." *University of Toronto Law Journal* 39 (1989): 217-57.
- Greschner, D. "Abortion and Democracy for Women: A Critique of Tremblay v. Daigle." *McGill Law Journal* 35 (1990): 633-69.

- Hanigsberg, J.E. "Power and Procreation: State Interference in Pregnancy." *Ottawa Law Review* 23 (1991): 35-70.
- Hanis, N.M., and S.C. Phillips. "Considerations in the Development of a Reproductive Surveillance System for Exxon." *The Medical Bulletin* 43 (1983): 3-29.
- Hatch, A., and K. Faith. "The Female Offender in Canada: A Statistical Profile." *Canadian Journal of Women and the Law* 3 (1989-90): 432-56.
- Heppner, B., and L. Davies. *Analysts of the Division of Labour and the Labour Force in Social Service Structures in Québec: Towards a New Definition of Professionalism*. Study prepared for Commission d'Enquête sur les services de santé et les services sociaux. Quebec: Publications Québec, 1986.
- Hill, L.M., D. Parker, and B.P. O'Neill. "Management of Maternal Vegetative State During Pregnancy." *Mayo Clinic Proceedings* 60 (1985): 469-72.
- Hoadley, D.L. "Fetal Protection Policies — Effective Tools for Gender Discrimination." *Journal of Legal Medicine* 12 (1991): 85-104.
- Holt, K.E. "Nine Months to Life — The Law and the Pregnant Inmate." *Journal of Family Law* 20 (1981-82): 523-43.
- Howard, J. "Chronic Drug Users as Parents." *Hastings Law Journal* 43 (1992): 645-60.
- Hughes, K.A., and H.T.G. Andrews. "Children's and Family Rights and the Role of the State in Custody and Child Protection Matters." Unpublished paper on file with author.
- Institut Suédois. "Feuillet de documentation sur la Suède: l'égalité entre l'homme et la femme." Stockholm: Institut Suédois, October 1989.
- Inter-American Commission on Drug Policy. *Seizing Opportunities*. San Diego: University of California, Institute of the Americas and the Center for Iberian and Latin American Studies, 1991.
- Jackman, M. "The Constitution and the Regulation of New Reproductive Technologies." In *Overview of Legal Issues in New Reproductive Technologies*. Vol. 3 of the research studies of the Royal Commission on New Reproductive Technologies. Ottawa: Minister of Supply and Services Canada, 1993.
- Jiménez Butragueño, M. "Protective Legislation and Equal Opportunity and Treatment for Women in Spain." *International Labour Review* 121 (1982): 185-98.
- Johnsen, D.E. "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection." *Yale Law Journal* 95 (1986): 599-625.
- . "Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty." *Hastings Law Journal* 43 (1992): 569-614.
- Johnson, P.E. "The ACLU Philosophy and the Right to Abuse the Unborn." *Criminal Justice Ethics* 9 (1990): 48.
- Johnston, J.D., G.G. Jamieson, and S. Wright. "Reproductive and Developmental Hazards and Employment Policies." Unpublished paper on file with the author, 1991.

- Jordan III, J.M. "Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women." *Georgia Law Review* 22 (1988): 1103-65.
- "Judge Is Firm on Forced Contraception but Welcomes an Appeal." *New York Times (National)* (11 January 1991): A 12.
- Kandall, S.R., and W. Chavkin. "Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women." *Hastings Law Journal* 43 (1992): 615-43.
- Katz, J.F. "Hazardous Working Conditions and Fetal Protection Policies: Women Are Going Back to the Future." *Boston College Environmental Affairs Law Review* 17 (1989): 201-30.
- Kaufman, K.R., and M.E. Weekes. "Juvenile Law and the Viable Fetus: Clinical Perspectives and Legal Intervention." *International Journal of Law and Psychiatry* 8 (1986): 471-82.
- Kay, H.H. "Equality and Difference: The Case of Pregnancy." *Berkeley Women's Law Journal* 1 (1985).
- Kaye, L. *Danger, Keep Out! Exclusionary Hiring Practices by Employers, Reproductive Hazards at Work*. Ottawa: National Association of Women and the Law, 1985.
- . *Reproductive Hazards in the Workplace: Some Cases*. Ottawa: National Action Committee on the Status of Women, 1986.
- Kenney, S.J. "Reproductive Hazards in the Workplace: The Law and Sexual Difference." *International Journal of the Sociology of the Law* 14 (1986): 393-414.
- Keyserlingk, E.W. "Clarifying the Right to Prenatal Care: A Reply to a Response." *Health Law in Canada* 4 (1983): 35-38.
- . "The Unborn Child's Right to Prenatal Care" (Part I; Part II). *Health Law in Canada* 3 (1982): 10-21; 31-41.
- . *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective*. Montreal: Quebec Research Centre of Private and Comparative Law, 1984.
- King, P.A. "The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn." *Michigan Law Review* 97 (1979): 1647-87.
- Klein, A., and W. Roberts. "Besieged Innocence: The 'Problem' and the Problems of Working Women, Toronto, 1896-1914." In *Women at Work, Ontario, 1850-1930*, ed. J. Acton, P. Goldsmith, and B. Shepard. Toronto: Canadian Women's Educational Press, 1974.
- Knoppers, B.M. *Conception artificielle et responsabilité médicale*. Cowansville: Yvon Blais, 1986.
- Kolder, V.E.B., J. Gallagher, and M.T. Parsons. "Court-Ordered Obstetrical Interventions." *New England Journal of Medicine* 316 (1987): 1192-96.
- Koren, G., ed. *Maternal-Fetal Toxicology: A Clinician's Guide*. New York: Marcel Dekker, 1990.
- Kronstadt, D. "Complex Developmental Issues of Prenatal Drug Exposure." *Future of Children* 1 (1991): 36-49.

- Kumpfer, K.L. "Treatment Programs for Drug-Abusing Women." *Future of Children* 1 (1991): 50-59.
- Laberge, D., and S. Roy. "Femmes et criminalité: le contrôle social est-il sexué? Une analyse des données statistiques québécoises." *Canadian Journal of Women and the Law* 3 (1989-90): 457-64.
- Labonte, R., and S. Penjold. "Canadian Perspective in Health Promotion: A Critique." *Health Education* 10 (1981): 4-9.
- Law Reform Commission of Canada. *Crimes Against the Foetus*. Working Paper 58. Ottawa: LRC, 1989.
- . *Homicide*. Working Paper 33. Ottawa: LRC, 1984.
- . *Recodifying Criminal Law*. Report 31. Ottawa: LRC, 1987.
- Leclercq, G.R. "Workplace Reproductive Risk: Corporate Responsibilities." *The Medical Bulletin* 43 (1983): 30-39.
- Logli, P.A. "Drugs in the Womb: The Newest Battlefield in the War on Drugs." *Criminal Justice Ethics* 9 (1990): 23.
- . "The Prosecutor's Role in Solving the Problems of Prenatal Drug Use and Substance Abused Children." *Hastings Law Journal* 43 (1992): 559-67.
- McConnell, M. "Capricious, Whimsical, and Aborting Women: Abortion as a Medical Criminal Issue (Again)." *Canadian Journal of Women and the Law* 3 (1989-90): 661-66.
- McConnell, M., and L. Clark. "Abortion Law in Canada: A Matter of National Concern." *Dalhousie Law Journal* 14 (1991): 81-89.
- MacCormick, N. *Legal Right and Social Democracy: Essays in Legal and Political Philosophy*. Oxford: Oxford University Press, 1982.
- McCullough, C.B. "The Child Welfare Response." *Future of Children* 1 (1991): 61-71.
- McGillivray, A. "Battered Women: Definition, Models and Prosecutorial Policy." *Canadian Journal of Family Law* 6 (1987): 15-45.
- McGinnis, D.M. "Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory." *University of Pennsylvania Law Review* 139 (1990): 505-39.
- McHugh, G.A. "Protection of the Rights of Pregnant Women in Prisons and Detention Facilities." *New England Journal of Prison Law* 6 (1980): 231-63.
- MacKenzie, J.A. *Judicial Intervention in Human Reproductive Processes: A Policy Profile*. Study prepared for the Royal Commission on New Reproductive Technologies, 1991.
- MacKinnon, C.A. "Reflections on Sex Equality Under Law." *Yale Law Journal* 100 (1991): 1281-1328.
- McLaren, A., and A.T. McLaren. *The Bedroom and the State*. Toronto: McClelland and Stewart, 1986.
- McNulty, M. "Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses." *New York University Review of Law and Social Change* 16 (1988): 277-319.

- Manitoba. Public Inquiry into the Administration of Justice and Aboriginal People. *Report of the Aboriginal Justice Inquiry of Manitoba. Volume I: The Justice System and Aboriginal People*. Winnipeg: The Inquiry, 1991.
- Manson, R., and J. Marolt. "A New Crime, Fetal Neglect: State Intervention to Protect the Unborn: Protection at What Cost?" *California Western Law Review* 24 (1987-88): 161-82.
- Marcotte, P. "Crime and Pregnancy." *American Bar Association Journal* (August 1989): 14, 16.
- Mariner, W.K., L.H. Glantz, and G.J. Annas. "Pregnancy, Drugs, and the Perils of Prosecution." *Criminal Justice Ethics* 9 (1990): 30.
- Maroney, H.J., and M. Luxton, eds. *Feminism and Political Economy: Women's Work, Women's Struggle*. Toronto: Methuen, 1987.
- Martin, S.L. *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms and the Canada Health Act*. Ottawa: Canadian Advisory Council on the Status of Women, 1989.
- "Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of 'Fetal Abuse.'" *Harvard Law Review* 101 (1988): 994-1012.
- Messing, K. *Occupational Safety and Health Concerns of Canadian Women*. Ottawa: Labour Canada, 1991.
- "Ministry Says Woman Can Refuse Work That Puts Fetus in Jeopardy." *Globe and Mail* (18 December 1982): 4.
- Mitchinson, W. "Historical Attitudes Toward Women and Childbirth." *Atlantis* 4 (2) (1979): 13.
- Monture, P.A. "A Vicious Circle: Child Welfare and the First Nations." *Canadian Journal of Women and the Law* 3 (1989): 1-17.
- . "The Voices of Aboriginal People." In *Correctional Service Canada, Creating Choices: The Report of the Task Force on Federally Sentenced Women*. Ottawa: Correctional Service Canada, 1990.
- Moss, D.C. "Pregnant? Go Directly to Jail." *American Bar Association Journal* (November 1988): 20.
- Moss, K. "Substance Abuse During Pregnancy." *Harvard Women's Law Journal* 13 (1990): 278-99.
- Murray, T.H. "Prenatal Drug Exposure: Ethical Issues." *Future of Children* 1 (1991): 105-12.
- Nelson, J.L. "Making Peace in Gestational Conflicts." *Theoretical Medicine* 13, (1992): 319-28.
- Nielsen, R. "Special Protective Legislation for Women in the Nordic Countries." *International Labour Review* 119 (1980): 39-49.
- "No Time Limit on Maintaining 'Dead' Mother to Save Fetus?" *Medical World News* (9 May 1983): 21.
- Nocon, J.J. "Physicians and Maternal-Fetal Conflicts: Duties, Rights and Responsibilities." *Journal of Law and Health* 5 (1990-91): 1-34.

- Nolan, K. "Protecting Fetuses from Prenatal Hazards: Whose Crimes? What Punishment?" *Criminal Justice Ethics* 9 (1990): 13.
- Noonan, S. "Protection of the Foetus: Denial of the Woman." *Canadian Journal of Women and the Law* 3 (1989-90): 667-72.
- . "What the Court Giveth: Abortion and Bill C-43." *Queen's Law Journal* 16 (1991): 321-45.
- Nova Scotia. *Code of Practice for Working with Lead* [pursuant to the Occupational Health and Safety Act, R.S.N.S. 1989, c. 320], April 1991.
- Oberman, M. "Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs." *Hastings Law Journal* 43 (1992): 505-48.
- O'Donovan, K. "Engendering Justice: Women's Perspectives and the Rule of Law." *University of Toronto Law Journal* 39 (1989): 127-48.
- Olsham, A.F., K. Teschke, and P.A. Baird. "Birth Defects Among Offspring of Firemen." *American Journal of Epidemiology* 131 (1990): 312-21.
- Ontario Advisory Council on Occupational and Environmental Health. Special Studies and Projects Sub-Committee. *Report on Occupational Hazards to the Fetus in the Case of Pregnant Women in the Work Force*. Toronto: 1977.
- Ontario. Ministry of Health. *Report on Therapeutic Abortion Services in Ontario*. Toronto: The Ministry, 1987.
- Ontario. Ministry of Labour. *Designated Substances in the Workplace: A Guide to the Lead Regulation*. Toronto: Queen's Printer for Ontario, 1985.
- . *Working in Ontario — An Employee's Guide to Working in Ontario*. Toronto: Queen's Printer for Ontario, 1990.
- Osborne, J.A. "The Crime of Infanticide: Throwing Out the Baby with the Bathwater." *Canadian Journal of Family Law* 6 (1987): 47-59.
- Overall, C. "Mother/Fetus/State Conflicts." *Health Law in Canada* 9 (1989): 101-103, 122.
- . Overall, C. "Pluck a Fetus from Its Womb: A Critique of Current Attitudes Toward the Embryo/Fetus." *University of Western Ontario Law Review* 24 (1986): 1-14.
- Overall, C., ed. *The Future of Human Reproduction*. Toronto: Women's Press, 1989.
- Paltiel, F.L. "State Initiatives — Impetus and Effects." Paper delivered at the conference "Women and the Canadian State." University of Ottawa, November 1990.
- Paltrow, L.M. "When Becoming Pregnant Is a Crime." *Criminal Justice Ethics* 9 (1990): 41.
- Paoli, C. "Women Workers and Maternity: Some Examples from Western Europe." *International Labour Review* 121 (1982): 1-16.
- Parness, J.A. "Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life." *Harvard Journal of Legislation* 22 (1985): 97-172.
- Parness, J.A., and S.K. Pritchard. "To Be or Not to Be: Protecting the Unborn's Potentiality of Life." *University of Cincinnati Law Review* 51 (1982): 257-98.

- Pilon, M. *Les enjeux socio-sanitaires au Québec: Les besoins de la population.* Québec: 1987.
- Poirier, D. "Social Worker Enforcement of Child Welfare Legislation: An Increasing Potential for Abuse of Power." *Canadian Journal of Family Law* 5 (1986): 215-35.
- Reid, A. "Daughter Born to Woman in a Coma." *New York Times* (17 March 1985): 46.
- Reitsma-Street, M. "More Control Than Care: A Critique of Historical and Contemporary Laws for Delinquency and Neglect of Children in Ontario." *Canadian Journal of Women and the Law* 3 (1989-90): 510-30.
- "Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy." *Harvard Law Review* 103 (1990): 1325-43.
- Rhoden, N.K. "The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans." *California Law Review* 74 (1986): 1951-2030.
- Ricks, S. "The New French Abortion Pill: The Moral Property of Women." *Yale Journal of Law and Feminism* 1 (1989): 75-99.
- Ridder, S., and L. Woll. "Transforming the Grounds: Autonomy and Reproductive Freedom." *Yale Journal of Law and Feminism* 2 (1989): 75-98.
- Roberts, D.E. "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy." *Harvard Law Review* 104 (1991): 1419-82.
- Robertson, J.A. "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth." *Virginia Law Review* 69 (1983): 405-64.
- Robin-Vergeer, B.I. "The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention." *Stanford Law Review* 42 (1989-90): 745-809.
- Rodgers, S. "Fetal Rights and Maternal Rights: Is There a Conflict?" *Canadian Journal of Women and the Law* 1 (1986): 456-69.
- . "Pregnancy as Justification for Loss of Juridical Autonomy." In *The Future of Human Reproduction*, ed. C. Overall. Toronto: Women's Press, 1989.
 - . "Regulation of Abortion in Canadian Law." Ottawa: University of Ottawa, Faculty of Law, n.d.
- Rosenbaum, M. "Just Say What? An Alternative View on Solving America's Drug Problem." New York: National Council on Crime and Delinquency, 1989.
- Rouse, F. "Advance Directives: Where Are We Heading After *Cruzan*?" *Law, Medicine and Health Care* 18 (1990): 353-59.
- Royal College of Physicians and Surgeons of Canada. Biomedical Ethics Committee. *Reflection on the Physician's Responsibility to Mother and Fetus*. Submission to the Royal Commission on New Reproductive Technologies, Ottawa, 1990.
- Ruhle, N. "Perinatal Substance Abuse: Personal Triumphs and Tragedies." *Hastings Law Journal* 43 (1992): 549-58.
- Saskatchewan. Ministry of Labour. *Antineoplastic Drugs*. Regina: Ministry of Labour, Occupational Health and Safety Branch, 1991.
- . *Code of Practice for Work Involving the Use of Visual Display Units*. In *Saskatchewan Gazette*, 7 March 1989.

- . *Pregnant Women and Hazards of Workplace Chemicals — Technical Backgrounder*. Regina: Ministry of Labour, Occupational Health and Safety Branch, 1991.
 - . *Recommended Guidelines for Medical Monitoring of Vehicle Radiator Shop Workers Exposed to Inorganic Lead*. Regina: Ministry of Labour, Occupational Health and Safety Branch, 1991.
- Schiff, N.K. "Legislation Punishing Drug Use During Pregnancy: Attack on Women's Rights in the Name of Fetal Protection." *Hastings Constitutional Law Quarterly* 19 (1991): 197-234.
- Schoen, W.L. "Conflict in the Parameters Defining Life and Death in Missouri Statutes." *American Journal of Law and Medicine* 16 (1990): 555-80.
- Science Council of Canada. *Politics and Poisons: The Containment of Long-Term Hazards to Human Health in the Environment and in the Workplace*. Ottawa: Science Council of Canada, 1977.
- Shaw, J.W. "Social Policy: Pregnancy Discrimination in Sex Discrimination." *European Law Review* 16 (1991): 313-20.
- Shaw, M. "Conditional Prospective Rights of the Fetus." *Journal of Legal Medicine* 5 (1984): 63-116.
- Sklar, K.K. "Hull House in the 1890's: A Community of Women Reformers." *Signs* 10 (1985): 658-77.
- Smirnov, S.A. "Maternity Protection: National Law and Practice in Selected European Countries." *International Social Security Review* 32 (1979): 420-44.
- Sor, Y. "Fertility or Unemployment — Should You Have to Choose?" *Journal of Law & Health* 1 (1986-87): 141-228.
- Speck, D.C. "The Indian Health Transfer Policy: A Step in the Right Direction, or Revenge of the Hidden Agenda?" *Native Studies Review* 5 (1989): 187-213.
- Stefan, S. "Whose Egg Is It Anyway? Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women." *Nova Law Review* 13 (1989): 405-56.
- Steinberg, D.M. *Family Law in the Family Courts*. Vol I. 2d ed. Toronto: Carswell, 1981.
- Stellman, J.M. "Protective Legislation and Occupational Hazards: Flawed Science and Poor Policies." In *Reproductive Laws for the 1990s*, ed. S. Cohen and N. Taub. Clifton: Humana Press, 1989.
- . *Women's Work, Women's Health*. New York: Pantheon Books, 1983.
- Studies on Women Abstracts*. Abingdon, Oxfordshire: Carfax, 1988.
- Sullivan, P. "CMA's Discussion Paper on Fetal Rights May Spark Debate." *Canadian Medical Association Journal* 143 (1990): 404-405.
- Sutter, C. "Du droit de la maternité au droit à la procréation." *Droit social* 11 (1981): 710.
- Swinton, K. "Accommodating Women in the Workplace: Reproductive Hazards and Seniority Systems." *Canadian Labour Law Journal* 1 (1992): 125-39.

- . "Regulating Reproductive Hazards in the Workplace: Balancing Equality and Health." *University of Toronto Law Journal* 33 (1983): 45-73.
- Tataryn, L. *Dying for a Living: The Politics of Industrial Death*. Ottawa: Deneau and Greenberg, 1979.
- Tateishi, S.A. "Apprehending the Fetus *En Ventre Sa Mère*: A Study in Judicial Sleight of Hand." *Saskatchewan Law Review* 53 (1989): 113-41.
- Thomas, E. *Issues and Priorities for Women's Health in Canada: A Key Informant Study*. Ottawa: Health and Welfare Canada, 1986.
- Thompson, E.L. "The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawmakers." *Indiana Law Journal* 64 (1989): 357-74.
- Townsend, E.L. "Maternal Drug Use During Pregnancy as Child Neglect or Abuse." *West Virginia Law Review* 93 (1991): 1081-1100.
- Trammell, R.S. "Fetal Rights — A Bibliography." *Northern Illinois University Law Review* 10 (1989): 69-87.
- Trudeau, G., and J.-P. Villaggi. "Le retrait préventif de la femme enceinte en vertu de la Loi sur la santé et la sécurité du travail: où en sommes-nous?" *Revue du barreau* 16 (1986): 477-90.
- United States. Congress. Office of Technology Assessment. *Reproductive Health Hazards in the Workplace*. Washington, DC: OTA, 1985.
- United States. National Council on Radiation Protection and Measurements. *Basic Radiation Protection Criteria*. NCRP Report 39. Washington, DC, 1971.
- Vallée, M. "De la contraception à l'avortement: outrage à l'autonomie des femmes." *Canadian Journal of Women and the Law* 3 (1989-90): 483-509.
- "Welfare Experts Sound Alarm." *Globe and Mail* (6 August 1991).
- West, R. "Love, Rage and Legal Theory." *Yale Journal of Law and Feminism* 1 (1989): 101-10.
- Williams, W.W. "Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII." *Georgetown Law Journal* 69 (1981): 641-704.
- Wyrobek, A.J. "Male Biomarkers of Abnormal Reproductive Outcome." *Health and Environment Digest* 4 (8)(1990): 1-4.
- Zuckerman, B. "Drug Exposed Infants: Understanding the Medical Risk." *Future of Children* 1 (1991): 26-35.

Cases

Australia

- A. G. Queensland v. T.* (1983), 57 Aust. L.J. Reports 285.
Attorney General v. T. (1983), 46 A.L.R. 275.
F. v. F. (12 July 1989), Australia (Fam. Ct.).
Re Marriage of F (1989), 13 Fam. L.R. 189.

Canada

- Ackerman v. McGoldrick*, [1990] B.C.J. No. 2832 (Prov. Ct.).
Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143.
Bliss v. Attorney General of Canada, [1979] 1 S.C.R. 183.
Brooks v. Canada Safeway Ltd., [1989] 1 S.C.R. 1219.
Central Alberta Dairy Pool v. Alberta (Human Rights Commission) (1990), 72 D.L.R. (4th) 417 (S.C.C.).
Children's Aid Society of Peel (Region) v. S.(P.) (1991), 34 R.F.L. (3d) 157.
Dehler v. Ottawa Civic Hospital (1979), 101 D.L.R. (3d) 686.
Diamond v. Hirsch (6 July 1989) (Man. Q.B.).
Emrick Plastics v. Ontario (Human Rights Commission) (1992), 90 D.L.R. (4th) 476 (Div. Ct.), aff'd (sub nom. Heincke v. Emrick Plastics) (1990), 91 C.L.L.C. 17,010 (Ont. Bd. of Inq. Hovius).
J.M. v. Superintendent of Family and Child Services (1983), 35 R.F.L. (2d) 364, (B.C.C.A.), aff'd (sub nom. *Re Superintendent of Family and Child Services and McDonald*) (1982), 135 D.L.R. (3d) 330 (B.C.S.C.).
J.S.C. v. Wren (1986), 49 Alta. L.R. (2d) 289.
Joe v. Director of Family and Children's Services (Yukon) (1987), 1 Y.R. 169.
Jones v. The Queen, [1986] 2 S.C.R. 284.
Malette v. Shulman (1987), 63 O.R. (2d) 243.
Medhurst v. Medhurst (1984), 9 D.L.R. (4th) 252.
Mills v. The Queen, [1986] 1 S.C.R. 863.
Montreal Tramways v. Léveillé, [1933] S.C.R. 145.
Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202.
Ontario Human Rights Commission and O'Malley v. Simpsons-Sears Ltd., [1985] 2 S.C.R. 536.
R. v. Hess and Nguyen, [1990] 2 S.C.R. 906.
R. v. MacKenzie (3 August 1988), Transcript of Guilty Plea and Submissions to Sentencing (Ont. Prov. Ct., Hogg, J.).
R. v. Morgentaler (1988), 37 C.C.C. (3d) 449.
R. v. Seaboyer, [1991] 2 S.C.R. 577.
R. v. Smith (1976), 32 C.C.C. (2d) 224.
R. v. Sullivan and LeMay, [1991] 1 S.C.R. 489.
R. v. Swain, [1991] 1 S.C.R. 933.
R. v. Therens, [1985] 1 S.C.R. 613.
R. v. Turpin, [1989] 1 S.C.R. 1296.
R. v. Videoflicks Ltd. (1984), 30 C.C.C. (3d) 385.
Re A. (in utero) (1990), 75 O.R. (2d) 82.
Re Baby R. (1988), 53 D.L.R. (4th) 69 (B.C.S.C.), rev'd (sub nom. *Re R.*) (1987), 9 R.F.L. (3d) 415 (B.C. Prov. Ct.).
Re Cadeddu and The Queen (1982), 4 C.C.C. (3d) 97 (Ont. H.C.).
Re Children's Aid Society of City of Belleville, Hastings County and T et al. (1987), 59 O.R. (2d) 204.
Re Children's Aid Society for the District of Kenora and J.L. (1981), 134 D.L.R. (3d) 249.
Re General Motors of Canada Ltd. and United Automobile Workers, Local 222 (1979), 24 L.A.C. (2d) 388.
Re R. (1987), 9 R.F.L. (3d) 415 (B.C. Prov. Ct.). See also *Re Baby R.*

Re Superintendent of Family and Child Services and McDonald (1982), 135 D.L.R. (3d) 330. See also *J.M. v. Superintendent of Family and Child Services*.
Reference re s. 94(2) of the Motor Vehicle Act (B.C.), [1985] 2 S.C.R. 486.
RWDSU v. Dolphin Delivery Ltd., [1986] 2 S.C.R. 573.
Seede et al. v. Camco Inc. (1985), 50 O.R. (2d) 218, (1986), 55 O.R. (2d) 352.
Thomson Newspapers Ltd. v. Canada (Director of Investigation and Research, Restrictive Trade Practices Commission), [1990] 1 S.C.R. 425.
Tremblay v. Daigle, [1989] 2 S.C.R. 530.
Wiens v. Inco Metals Company, Ontario Division (1988), 9 C.H.R.R. 4795 (Ont. Bd. of Inq.).

Europe

Bruggemann and Scheutin v. The Federal Republic of Germany (1978), 10 Eur. Comm'n on Human Rights Decisions and Reports.
Dekker v. VJV-Centrum, [1991] 1 R.L.R. 27.
Paton v. United Kingdom (1981), 3 E.H.R.R. 408 (European Commission of Human Rights).
X. v. The United Kingdom (1980), 19 Eur. Comm'n on Human Rights Decisions and Reports.

United Kingdom

B. v. Islington Health Authority, [1991] 1 All E.R. 825.
Berkshire County Council v. D., [1987] 1 All E.R. 20 (House of Lords).
Brown v. Stockton-on-Tees Borough Council, [1988] Weekly Law Reports 935 (H.L.).
C. v. S., [1987] 1 All E.R. 1230.
Clayton v. Vigers, [1989] Industrial Cases Reports 713 (Employment Appeal Tribunal).
Grimby Carpet Co. Ltd. v. Bedford, [1987] Industrial Cases Reports 975 (Employment Appeal Tribunal).
Hayes v. Malleable Men's Club, [1985] Industrial Cases Reports 703 (Employment Appeal Tribunal).
In re F. (in utero), [1988] 2 W.L.R. 1288 (C.A.).
McKay v. Essex Area Health Authority, [1982] 2 All E.R. 771 (C.A.).
Page v. Freight Hire (Tank Haulage) Ltd., [1981] 1 All E.R. 394.
Paton v. British Pregnancy Advisory Service Trustees, [1979] Q.B. 276.
Paton v. Trustees of BPAS, [1978] 2 All E.R. 987.
Webb v. Emo Air Cargo (U.K.) Ltd., [1990] Industrial Cases Reports 443 (Employment Appeal Tribunal).

United States

Bonrest v. Kotz (1946), 65 F. Supp. 138.
California v. Stewart, Civ. No. 575396 (Mun Ct Calif, San Diego County, 1987).
City Bank Farmers Trust Co. v. McGowan (1945), 323 U.S. 594.
Cox v. Court (1988), 537 N.E. 2d 721.
Craig v. Boren (1976), 429 U.S. 190.
Crouse Irving Memorial Hospital Inc. v. Paddock (1985), 485 N.Y.S. 2d 443.
Cruzan v. Director, Missouri Department of Health (1990), 110 S. Ct. 2841.
Dintno v. State ex rel. Gorton (1984), 684 P. 2d 1297.
Doe v. Bolton (1973), 410 U.S. 179.
Doe v. Director of the Department of Social Services (1991), 468 N.W. 2d 862.
Dothard v. Rawlinson (1977), 433 U.S. 334.

- Eisenstadt v. Baird* (1972), 405 U.S. 438.
Florida v. Jennifer Clarise Johnson. See *Johnson v. State*.
Griswold v. Connecticut (1965), 381 U.S. 479.
Grondin v. Grondin (1981), 301 N.W. 2d 869.
Harris v. McCarthy, No. 8506002 W.M.B. (C.D.Ca) (11 September 1985).
Harriss v. Pan Am World Airways Inc. (1980), 649 F. 2d 670.
Hayes v. Shelby Memorial Hospital (1984), 726 F. 2d 1543.
In re Valerie D. (1991), 595 A. 2d 922.
International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, U.A.W. v. Johnson Controls, Inc. (1991), 111 S. Ct. 1196, over-ruling 886 F. 2d 871 (7th Cir. 1989).
Jefferson v. Griffin Spalding County Hospital Authority (1981), 274 S.E. 2d 457.
Johnson v. State (1991), 578 So. 2d 419, aff'd (sub nom. *Florida v. Jennifer Clarise Johnson*) Seminole Cty., Florida, E 89-890-CFA.
Jones v. Dyer, No. H-114154-O (Sup. Ct. Alameda Cty., Ca.) (25 February 1986).
Lawrence v. State (1991), 409 S.E. 2d 661.
Loving v. Virginia (1967), 388 U.S. 1.
MacDonnell Douglas Corporation v. Green (1973), 411 U.S. 792.
Miccols v. Amica Mutual Insurance Company (1991), 587 A. 2d 67.
Michigan v. Kimberly Hardy (1991), No. 128458 (Michigan C.A.).
Nashville Gas Co. v. Satty (1977), 434 U.S. 136.
People v. Ford (1991), 581 N.E. 2d 1189.
People v. Kuchan (1991), 579 N.E. 2d 1054.
Petit v. Chester County Hospital, Civil Action No. 322 (C.P. Chester County, Pa.) (25 August 1982).
Prince v. Massachusetts (1944), 321 U.S. 158.
Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson (1964), 201 A. 2d 537.
Re A.C. (1987), 533 A. 2d 611 (1990) 573 A. 2d 1235.
Re Amie M. (1986), 225 Cal. Rptr. 645.
Re Baby X (1980), 293 N.W. 2d 736.
Re Dittrick (1977), 263 N.W. 2d 37.
Re D.K. (1985), 497 A. 2d 1298.
Re Fletcher (1988), 533 N.Y.S. 2d 241.
Re Jamaica Hospital (1985), 491 N.Y.S. 2d 898.
Re Klein (1989), 538 N.Y.S. 2d 274.
Re Lynda McCranie, No. DI-88-104 Montana (Mont. 13th Jud. Dist. Ct., Yellowstone Cty.) (July 1988).
Re Madyun (1990), 573 A. 2d 1259.
Re Milland (1989), 548 N.Y.S. 2d 995.
Re M.M.M. (1984), 485 A. 2d 180.
Re President & Directors of Georgetown College Inc. (1964), 331 F. 2d 1000.
Re Quinlan (1976), 355 A. 2d 647.
Re Rutz (1986), 500 N.E. 2d 935.
Re Stefani Tyesha C. (1990), 556 N.Y.S. 2d 280.
Re Stephen W. (1990), 271 Cal. Rptr. 319.
Re Steven S. (1981), 126 Cal. App. 3d 525.
Re Troy D. (1989), 263 Cal. Rptr. 869.
Roe v. Wade (1973), 410 U.S. 113.
San Antonio Independent School District v. Rodriguez (1973), 411 U.S. 1.

Seef v. Sutkus (1991), 583 N.E. 2d 510.
Skinner v. Oklahoma (1942), 316 U.S. 535.
Stallman v. Youngquist (1988), 531 N.E. 2d 355.
State v. Bauer (1991), 471 N.W. 2d 363.
State v. Gethers (1991), 585 So. 2d 1140.
Taft v. Taft (1983), 446 N.E. 2d 395.
United States v. Vaughn, Crim. No. F 2172-88 (D.C. Super. Ct.), (23 August 1988).
University Health Services, Inc. v. Plazzl, Civil Action File No. CV86-RCCV-464, Richmond Cty., Georgia (unreported).
Webster v. Reproductive Health Services (1989), 109 S. Ct. 3040.
Wright v. Olin Corp. (1982), 697 F. 2d 1172.
Wyoming v. Pfannenstiel, No. 1-90-8CR (Laramire County Ct.), (5 January 1990).
Yeager v. Smith, No. CV-F-87-493 (E.D.Cal.) (2 September 1987).

Statutes

Canada

An Act for consolidating ... Offences against the person, 1841 (Upper Can.), 4 & 5 Vict., c. 27.
An Act ... for the further prevention of the malicious using of means to procure the miscarriage of women, 1810 (N.B.), 50 Geo. III, c. 2.
An Act for the Promotion and Protection of the Health and Safety of Persons Engaged in Occupations, R.S.S. 1978, c. O-1.
An Act for the Promotion and Protection of the Health and Safety of Persons Engaged in Occupations, S.S. 1989, c. O-1.
An Act further to amend the Law relating to Offences against the Person, 1842 (N.B.), 5 Vict., c. 33.
An Act Relating to Treasons and Felonies, 1758 (N.S.), 32 Geo. II, c. 13.
An Act Relating to Treasons and Felonies, 1792 (P.E.I.), 33 Geo. III.
An Act Respecting Consent to Medical Treatment, R.S.N.S. 1989, c. 279.
An Act Respecting Occupational Health and Safety, R.S.Q., c. S-2.1.
An Act Respecting Offences against the Person, 1859 C.S.C. (Can.), 22 Vict., c. 91.
An Act Respecting Offences against the Person, 1869 (Can.), 32 & 33 Vict., c. 20.
An Act to Amend the Human Rights Act, S.N.B. 1992, c. 30.
An Act to amend the Statute Law, relative to offences against the Person ..., 1829 (N.B.), 9 & 10 Geo. IV, c. 21.
An Act to extend the Criminal Laws of England to this Colony, 1837 (Nfld.), 1 Vict., c. 4.
Atomic Energy Control Act, SOR/DORS/85-335. Canada Gazette Part II, Vol. 119, No. 9.
Bill 8, An Act Respecting Natural Death, 39 Elizabeth II, 1990 (Ont.).
Bill 108, An Act to Provide for the Making of Decisions on Behalf of Adults Concerning the Management of Their Property and Concerning Their Personal Care, 40 Elizabeth II, 1991 (Ont.).
Bill 109, An Act Respecting Consent to Treatment, 40 Elizabeth II, 1991 (Ont.).
Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B of the Canada Act 1982 (U.K.), 1982, c. 11.
Charte des droits et libertés de la personne, R.S.Q. 1977, c. 12.
Child and Family Services Act, S.O. 1984, c. 55.

Child Welfare Act, R.S.O. 1980, c. 66.
Children's Act, S.Y.T. 1984, c. 2.
Constitution Act 1982, being Schedule B of the Canada Act 1982 (U.K.), 1982, c. 11.
The Criminal Code, 1892 (Can.), 55 & 56 Vict., c. 29.
Criminal Code, R.S.C. 1985, c. C-46.
Fair Practices Act, R.S.N.W.T. 1974, c. F-2.
Family and Child Service Act, S.B.C. 1980, c. 11.
Family Services Act, S.N.B. 1980, c. F-2.2.
Guide to the Lead Regulation, O. Reg. 536/81 as amended by O. Reg. 23/87.
Human Rights Act, R.S.N.B. 1973, c. H-11.
Human Rights Act, R.S.N.S. 1989, c. 214.
Human Rights Act, S.B.C. 1984, c. 22.
Human Rights Act, S.P.E.I. 1975, c. 72.
Human Rights Act, S.Y. 1987, c. 3.
Human Rights Code, S.M. 1987, c. 45.
Human Rights Code, S.N. 1988, c. 62.
Human Rights Code, S.O. 1981, c. 53.
Individual's Rights Protection Act, R.S.A. 1980, c. I-2.
Mental Health Act, R.S.O. 1980, c. 262.
Occupational Health and Safety Act, R.S.O. 1980, c. 321.
Occupational Health and Safety Act, R.S.N.S. 1989, c. 320.
Radiation Protection Act, R.S.A. 1985, c. R-2.1.
Radiation Protection Regulation, Alberta Reg. 162/90, 27 June 1990.
Regulation Respecting Mercury, O. Reg. 141/82 as amended by O. Reg. 23/87.
The Saskatchewan Human Rights Code, S.S. 1979, c. S-24.1.
X-Ray Safety, O. Reg. 632/86.

United Kingdom

An Act for the further Prevention of malicious shooting, and attempting to discharge loaded Fire-Arms ... and also for repealing 'An Act to prevent the destroying and murdering of Bastard Children', 1803 (Eng.), 43 Geo. III, c. 58.
An Act for the further prevention of malicious shooting, and attempting to discharge loaded fire-arms, ... and the malicious using of Means to procure the Miscarriage of Women 1803 (Eng.), 43 Geo. III, c. 53.
Children and Young Persons Act, 1969.
Employment Act, 1989.
Employment Protection (Consolidation) Act, 1978.
Sex Discrimination Act, 1975.

United States

Alaska Statutes, s. 18.12.040(c) (1986).
An Act concerning crimes and punishments; relating to conditions of probation, Kansas, Session of 1991, House Bill 2255, s. 3(d).
An Act to amend section 11165 of the Penal Code, relating to crimes. Senate Bill, no. 1070, as amended 20 April 1987.
An Act to Amend the Civil Rights Law, in Relation to the Rights of Pregnant Women ..., New York, 9286-C in Assembly, 8 February 1990; 7791-C in Senate 27 March 1990.
California Penal Code, s. 187, s. 270 (West 1988).
California Health & Safety Code, s. 7188 (Supp. 1987).

Civil Rights Act, 42 U.S.C. s. 2000e et seq. (1964), as amended by the Pregnancy Discrimination Act, 42 U.S.C. s. 2000(e)(k) (1982).

Civil Rights Act of 1990, s. 2104, 101st Congress, 2d Sess. (1990).

Connecticut General Statutes Annotated, s. 19a-574 (Supp. 1987).

D.C. Code, s. 2-1352, s. 16-2301 (Supp. 1990).

Delaware Code Annotated, title 16, s. 2503(d) (1983).

Florida Statutes Annotated, s. 165.08, s. 765.05 (Supp. 1986).

Florida Statutes Annotated, s. 415.503(8) (West 1989).

Florida Statutes Annotated, s. 415.503(8)(a)(2) (1986 & Supplement 1989).

Georgia Code Annotated, s. 31-32-8(a)(1), s. 31-32-11(a) (1985).

Georgia Code Annotated, s. 31-32-3(b) (Supp. 1987).

Hawaii Revised Statutes, s. 350-1(3), s. 587-2 (1985).

Hawaii Revised Statutes, s. 327D-6 (Supp. 1986).

House Bill 2835, 86th General Assembly, State of Illinois (1989 and 1990), amending ch. 38, new s. 12-4.7 (LRB8607533RCm6).

Illinois Annotated Statutes, ch. 110 1/2, s. 703(c) (Supp. 1987).

Illinois Annotated Statutes, ch. 38, para. 9-1.2 (Smith-Hurd 1988).

Illinois Juvenile Court Act, Ill. Rev. Stat. (1989) ch. 37, para. 802-3, s. 2-3(1)(c).

Illinois Revised Statutes, ch. 37, 802-3(c) (1989).

Indiana Code Annotated, s. 31-6-4-3.1 (Burns 1987).

Iowa Code Annotated, s. 144A 6.2, 7.3 (Supp. 1987).

Iowa Code Annotated, s. 707.7 (West 1979).

Kansas, Session of 1991, House Bill No. 2089, s. 1(a).

Kansas Statutes Annotated, s. 65-28, 103 (1985).

Maryland Health-General Code Annotated, s. 5-605(2) (Supp. 1987).

Massachusetts General Laws Annotated, ch. 119, s. 51A (West Supp. 1988).

Maternal and Child Health Services Act, 1989 Rhode Island Public Laws 252.

Michigan Comp. Laws Annotated, s. 750.322 (West 1968).

Minnesota Statutes, s. 626.556 (1988).

Mississippi Code Annotated, s. 41-41-107 (Supp. 1986).

Mississippi Code Annotated, s. 97-3-37 (1973).

Montana Code Annotated, s. 50-9-202(3) (1987).

Montana Revised Statutes, s. 459.205 (Supp. 1987).

Nevada Revised Statutes, s. 449.610 (1985).

Nevada Revised Statutes Annotated, s. 432 B.330 (Michie 1989).

New Hampshire Revised Statutes Annotated, s. 137H:14(1) (Supp. 1986).

New Hampshire Revised Statutes Annotated, s. 585.13 (1986).

New York Penal Law, s. 125.00 (McKinney 1987).

Ohio Senate Bill No. 324, s. 2919.221(B)(2)(c); s. 2919.221(E).

Oklahoma Statutes Annotated, title 10, s. 1101 (West 1989).

Oklahoma Statutes Annotated, title 21, s. 713 (West 1983).

Oklahoma Statutes Annotated, title 21, s. 846 (West 1989).

Oklahoma Statutes Annotated, title 63, s. 3103 (Supp. 1987).

South Carolina Code Annotated, s. 44-77-70 (Supp. 1986).

State of New York, 9286-C, in Assembly, 8 February 1990; 7791-C, in Senate, 27 March 1990.

Texas Revised Civil Statutes Annotated, art. 4590h, s. 3(d) (Vernon Supp. 1987).

Utah Code Annotated, s. 62A-4-504 (1989).

Utah Code Annotated, s. 75-2-1109 (Supp. 1987).

Utah Code Annotated, s. 76-5-201 (1988).

Washington Revised Code Annotated, s. 9A.32.060 (1988).

Washington Revised Code Annotated, s. 70.122.030(1)(c) (Supp. 1987).

Wisconsin Statutes Annotated, s. 154.03(2) (Supp. 1986).

Wisconsin Statutes Annotated, s. 154.07(2) (Supp. 1986).

Wisconsin Statutes Annotated, s. 940.04 (West 1982).



Reproductive Hazards in the Workplace: Legal Issues of Regulation, Enforcement, and Redress

Judy Fudge and Eric Tucker



Executive Summary

The study provides a comprehensive analysis of the legal regulation of reproductive hazards in the workplace in Canada.

Occupational health and safety law, workers' compensation legislation, the civil law of torts, human rights legislation, and employment and labour law in the various jurisdictions (provincial, territorial, and federal) are examined and discussed as they impact on the regulation of reproductive hazards in the workplace. An overview of each of the various regimes is provided to situate the discussion of the particular regulatory response to workplace reproductive hazards. To provide clarity and ease of analysis, the shortcomings in the existing legal regimes are identified and discussed in the sections that describe and analyze the case law, legislation, and regulatory practices in each area.

The study concludes by offering a series of related recommendations identifying the major principles that should shape a coherent policy response to reproductive hazards in the workplace. A functional approach to this exercise is adopted, as any strategy designed to regulate reproductive hazards in the workplace must address the following key elements: equity, prevention, compliance and enforcement, and compensation. The recommendations have not been tailored to accord with

current mainstream calculations of political feasibility. Instead, the goal of the study is to develop proposals that will best achieve the goals of protecting workers from reproductive harm, compensating them when harm results, and doing this within an egalitarian framework.

I. Introduction

A. History and Ideology: The Perils of Protection

Early health and safety legislation in Canada singled out women and children for special protection.¹ Such legislation focussed on the possible adverse effects of work on women's health, offspring, mortality, and morality. Women were protected primarily as mothers, not as workers. Also, this concern for women's health in the workplace was selective in another way. It was directed primarily at women workers in factories, the majority of which were male-dominated.

Eventually, women were able to challenge successfully the legislation that restricted their employment. But while restrictive legislation is a thing of the past in Canada, "the theme of protection for women workers has not disappeared."² In its place, a new form of protectionism has surfaced,³ whereby individual industries and employers have expressed concern for women's reproductive capacity and the health and safety of fetuses; however, instead of preventing or minimizing the risk to women and fetuses by excluding the hazard, the typical corporate and, on occasion, public regulatory response has been to exclude fertile women. Moreover, neither employers nor policy makers have paid sufficient attention to reproductive hazards that might impact on men's reproductive capacities or on fetuses via the exposure of their fathers. The result is an unfortunate combination of policies that fail to adequately protect the reproductive health of workers and their offspring while exacerbating the problem of gender inequality and employment discrimination.

In many cases, the evidential basis for employment policies that exclude women workers from certain jobs has been impressionistic rather than scientific. The willingness of employers to exclude women without more substantial evidence contrasts sharply with their general tendency to insist that protective measures should not be required unless and until the risk is proven scientifically. Moreover, there has been a pronounced tendency to focus on the possibility of reproductive impairment to women who seek to enter traditionally male-dominated jobs at the expense of reproductive hazards that might affect women in traditionally female-dominated jobs. The extent to which employers rely on policies that exclude fertile women from traditionally male workplaces is unknown, although research suggests that it is quite widespread in the United States.⁴

As women and unions have become aware of exclusionary policies, employers in Canada and the United States have been confronted with human rights complaints on the grounds that exclusionary policies directed at fertile women constitute a *prima facie* case of sex discrimination. The U.S. Supreme Court recently stated that employers will not be able to defend such policies on the grounds that they are warranted as a form of fetal protection.⁵ This decision has been celebrated as a major victory by advocates of equal employment opportunities for women.⁶ But the problem with this decision is that it is a form of "equality with a vengeance":⁷ both women and men have equal rights to sacrifice the health of their offspring in exchange for relatively well-paying employment. While there is reason to suspect many fetal protection policies that exclude women as an invidious form of occupational segregation, there are legitimate concerns for fetal health in many workplaces. Moreover, most known reproductive toxins have other adverse effects on the health of adult workers.⁸

In Canada, where the case law is much less developed, it appears that fetal protection policies designed to minimize the potential liability of employers for prenatal exposure to surviving children can, if supported by scientific evidence, constitute a defence to a human rights complaint.⁹ However, since the various human rights commissions may, and do, take different approaches to the issue of exclusionary policies, employers across Canada have no clear guidance as to how to balance the possibility of human rights complaints against the possibility of tort liability.

The public discourse about reproductive hazards historically has been framed or conceptualized in specific terms. Although the general operating assumptions are often implicit, it is useful to identify them. Typically, workers' reproductive health has been separated from occupational health and safety concerns generally. In part, this is because employers are worried about fetal protection. Fetuses are regarded as hypersusceptible to harm from substances that are often found in workplaces. In justifying protective policies for fetuses, employers point to their general concern for the health of the next generation and their desire to avoid potential liability for fetal damage. Unlike the workers, the vast majority of whom are covered by workers' compensation legislation, their offspring who are injured by prenatal exposure to workplace hazards can bring civil actions.

Joined to this concern with fetal vulnerability is the belief that hazards are transmitted primarily through the woman's body. Thus, fertile and pregnant women are the targets of the vast majority of exclusionary policies. The contribution of paternal exposure to fetal damage has generally been ignored. Consequently, women's interest in relatively well-paying employment in traditionally male-dominated industries and occupations is seen as conflicting with employers' and the public interest in fetal protection. Not only does this characterization of the problem obscure the fact that women's interest in employment conflicts with fetal protection only to

the extent that workplaces are hazardous to fetuses, it also ignores the fact that traditionally female-dominated occupations may also pose risks to fetal health.

There is nothing inevitable about the existence of reproductive hazards in the workplace. The level of hazard to which workers and their offspring are exposed depends on a range of choices, not the least of which is the employer's assessment of the cost of either cleaning up the workplace or implementing policies that accommodate the susceptibilities of workers. The process of making health and safety decisions is not an exercise in objective fact finding, but rather a value judgment in which economics, politics, and ethics are intimately connected.¹⁰ Fetal protection policies that exclude fertile women are prompted as much by economic as by health concerns, if not more so; they address only one form of economic effect — fetal damage — and only via maternal exposure.¹¹

B. The Barriers to Effective Regulation of Reproductive Hazards in the Workplace

Ideological assumptions and economic decisions have shaped the policy response to the problem of reproductive health hazards in the workplace. Moreover, the development of a coherent policy on reproductive health hazards has been inhibited by a number of problems, the most pervasive of which is lack of knowledge on which to base legal standards and mechanisms. We lack knowledge of:

1. human reproduction and what constitutes a standard or norm of reproductive health;
2. the causes of infertility and related reproductive problems;
3. the impact of the work environment on reproduction; and
4. the economic and human costs of different public policy responses.

Because reproductive dysfunction manifests itself in and through a variety of effects, and because these effects are difficult to measure, policy makers may never have complete information regarding the full extent of reproductive health dysfunction attributable to work. This lack of knowledge creates real problems for designing regulatory and compensatory mechanisms. A major issue is who should bear the burden of uncertainty. Uncertainty is, and always will be, a major component in the management of exposure to reproductive hazards. The fundamental question is determining the appropriate public policy response when faced with uncertainty.¹²

A second problem for developing a policy response to minimize reproductive hazards in the workplace is that the potential hazards affecting reproductive health are numerous and widespread. Occupational health and safety hazards are traditionally divided into five categories: chemical,

physical, biological, psychosocial, and ergonomic. Hazards in each of these categories can detrimentally affect the reproductive health of workers. Chemical reproductive hazards include anaesthetic gases, cytotoxic drugs, lead, pesticides, organic solvents, and mercury. Physical hazards potentially include radiation, temperature extremes, noise, and vibration. Biological reproductive hazards are usually infectious diseases such as rubella.

Psychosocial hazards, which include work overload and stress, can have a profound impact on people's lives. Women who must balance both domestic and work responsibilities bear a double burden. Despite the lack of scientific data demonstrating a causal connection between workplace stress and reproductive health, it is possible that stress could result in negative reproductive outcomes. Ergonomic factors, such as heavy lifting and static, confined working positions, also could constitute a hazard for pregnant women. In addition, shift work may interfere with the reproductive cycle of workers. Since reproductive hazards arise in the context of an entire workplace, studies focussing on particular aspects of work may fail to identify the scope of the problem.¹³

A third problem is that, at present, there is no coherent or consolidated public policy response to reproductive hazards in the workplace in any jurisdiction in Canada. Instead, discrete legal regimes have been invoked to deal with various aspects of the problem that present themselves. There has been no systematic inquiry into the dimensions of work-induced reproductive harm and the design of an appropriate, integrated regulatory response. Regulatory mechanisms that were not designed with reproductive hazards in the workplace in mind have been adapted on an ad hoc basis to deal with such contingencies. This has resulted in a complex interaction of different regulatory regimes, a complexity exacerbated by the fact that occupational health and safety, workers' compensation, and human rights are under the jurisdiction of the provinces, territories, and federal government.

At present, five discrete legal regimes in ten provinces, in two territories, and at the federal level touch on various aspects of reproductive health in the workplace. Not only does occupational health and safety legislation provide a mechanism for setting standards for potential hazards, it also provides workers with a right to know about workplace hazards, a right to refuse unsafe work, and mechanisms allowing them to participate in decisions about achieving and monitoring workplace safety. As well, in Quebec, this legislation entitles a pregnant or breast-feeding worker who obtains a medical certificate attesting that her working conditions may be physically dangerous to her unborn child, to herself by reason of her pregnancy, or to her nursing child to request temporary relocation or leave. Moreover, temporary reassignment or leave for workers who are temporarily susceptible to reproductive hazards in the course of their normal employment may be available under human rights legislation.

However, the issue of compensation during leave is an open question. Under the Quebec legislation, for example, employers bear the costs of reassignment or leave through the workers' compensation system. Temporary reassignment or leave, with or without full or partial compensation, may be covered by collective agreements or employment policies or plans. If employers are required to accommodate susceptible workers under human rights legislation, these costs may be borne by both the employer and other workers at a particular workplace.

Compensation in the event that reproductive harm results from work is also a complex issue. To the extent that the reproductive harm detrimentally affects a worker's income-earning capacity, the worker may be compensated for that harm by the workers' compensation system. Whether, and to what extent, such harm is compensated if it does not impair the income-earning capacity of a worker are unclear. This depends on the model of compensation employed in different jurisdictions. Tort law may be invoked to supplement the workers' compensation system where the substance that causes the harm is negligently provided by a manufacturer. As well, both employers and manufacturers are potentially liable for workplace hazards that result in harm to fetuses through parental exposure if the fetus is born alive. This is a highly speculative area of the law as there are no decided cases and because it is extremely difficult to establish both negligence and legal causation in prenatal injuries.

Each of the legal regimes that touches on reproductive hazards in the workplace is riddled with problems of coverage, access, and proof. Moreover, it is clear that reduction of preventable reproductive impairment would lessen the need for policies to deal with the consequences of impairment. The crucial problems in this regard are the identification of reproductive hazards in the workplace and the development of regulatory mechanisms to eliminate or substantially reduce the risk of exposure.

A fourth barrier is that under existing Canadian legislation there is generally no obligation to test substances and processes for their effect on workers' health before or after they are introduced into the work environment. While in some situations manufacturers are obliged to test new chemicals, many chemicals and processes used in work processes have not been tested for their impact on worker health generally, let alone their impact on reproductive health. There is no requirement for standard testing procedures. In addition, in the vast majority of cases, the synergistic effects of chemicals as they interact in the work environment are unknown.

The absence of a general requirement to test new chemicals and processes *before* they are introduced into the workplace is supported, in part, by an implicit presumption that manufacturers and employers are free to produce and use whatever substances and processes they choose until someone demonstrates that they cause harm.¹⁴ Moreover, the standard of proof is likely to be a very high one, adopted from the scientific community. Too often this results in risk assessments¹⁵ being performed

only after evidence has accumulated that harm is being caused, and the evidence, more likely than not, will be the impairment suffered by workers and their offspring. This approach to testing allocates the costs of uncertainty in a particular way. Workers will bear a large share of these costs, but not all of them. Employers also pay some of the costs directly through workers' compensation and other insurance premiums, as does society as a whole through the provision of socialized medical and welfare services.

A final barrier to effective regulation is that unequal power relations in the workplace influence market and public policy responses to reproductive hazards. Workers in general can do little to inhibit an employer's decision to introduce new technologies, processes, and substances into the workplace through bargaining. Only in unionized workplaces do workers have a say about how the work process is organized. Even then, the vast majority of key production decisions go unchallenged. In non-unionized settings, workers fear employer retaliation if they raise health and safety concerns. Since the economic viability of enterprises is the central preoccupation of employers (and workers), health and safety issues generally take a back seat to the quest for increased productivity. Moreover, even when workers challenge aspects of production, they have no way of knowing if the employer's assessment of the cost of improving health and safety in the workplace is correct. In the area of public policy, with rising unemployment and the breakdown of secure employment, improved occupational health and safety will likely be seen as a luxury that workers, employers, and governments can ill afford. Employers' threats to relocate outside of the jurisdiction make it even harder for governments to impose more rigorous health and safety standards.

C. Regulatory Strategies

In part, the exercise of developing public policy depends on identifying the various parties and interests at stake and allocating financial and health costs and burdens. Protecting the reproductive health of male and female workers is necessary because reproductive capacity is fundamentally important to individuals and society. However, it is impossible to fully separate reproductive health from the overall health of workers. A visible, serious, and persistent commitment to health and safety by both employers and workers is crucial to preventing workplace impairment of reproductive function.

The complexity of the legal response to the problem of identifying and regulating reproductive hazards in the workplace can be alleviated by substituting a functional approach for the current approach of relying on established legal categories devised without specific consideration to the prevention and compensation of reproductive harms that arise during employment. Analytically, any strategy designed to address the problems of reproductive hazards in the workplace can be divided into three broad

functional categories: (1) prevention of reproductive harm; (2) compliance and enforcement; and (3) compensation for reproductive harm resulting from work. As well, the principle of equity should guide the development of public policy designed to address these three functional components. Impressionistic evidence or stereotypical assumptions should not be used as a basis for policies that exclude women from relatively well-paying employment in traditionally male-dominated occupations.

Each of the functional elements of a regulatory regime designed to address the problem of reproductive hazards can be divided, in turn, into a number of constituent parts. Moreover, there is a range of policy responses that weigh competing interests differently in each of the areas. If we focus on prevention, for example, it is important to identify and evaluate the range of prevention and control devices. Prevention as a form of primary control is designed to address the problem of reproductive hazards at the source. Identification of reproductive hazards is a first step. Measures to reduce the harms caused might include banning known toxins or lowering the level of exposure to them to make the workplace safer. Other forms of source control include changing how the work is done and/or implementing administrative controls that limit the length of exposure. For instance, intermediary controls would provide better ventilation to minimize the possibility of exposure. Last-resort control, the most common method, is directed at the worker and includes protective equipment and/or excluding hypersusceptible workers on a temporary or permanent basis.

A number of strategies have been identified for achieving the goal of protecting workers from reproductive impairment and their offspring from harm. Each of the strategies allocates the burden of improving reproductive health among the interested parties in a different manner. At one end of the spectrum, employers would be made to screen all processes and substances to determine whether they can be used without causing reproductive harm, and to eliminate those that do unless it is demonstrated that the social utility of exposing workers to harm far exceeds its social cost. This strategy is based on the premise that since employers cause the problem and have the greatest financial capacity to absorb the cost and/or pass it on to consumers, they should bear the costs of protecting workers. Thus, in the event that some level of exposure to a reproductive hazard was permitted, both male and female workers would be provided with relocation and leave-of-absence rights to accommodate periods of temporary reproductive susceptibility. Workers would not be required to bear the costs of these temporary strategies even to the extent that the employer would be required to provide rate and seniority retention. Of course, other allocations of these costs are possible and include shifting some of these costs to individual workers, throughout the workforce, or to a funded system.

At the other end of the spectrum, the burden of reproductive harm is shifted to workers by compelling them to assume the risks of exposure to a known or potential reproductive hazard as a condition of employment.

While employers might still bear the burden of tort liability for prenatal harms, workers would run the risk of reproductive impairment. To minimize their potential for liability, employers could be permitted to implement fetal protection policies, which shift the burden of preventing developmental hazards onto women workers by depriving them of access to traditionally well-paying jobs. If such a strategy were adopted, male workers would continue to shoulder some of the burden of reproductive hazards as they would be continuously exposed to situations that are known to cause, or are suspected of causing, harm.

D. Starting Premises

At the outset we wish to clearly state that we have made no attempt to estimate the proportion of reproductive impairment that is work-related. Nor, for that matter, have we made any independent judgments about whether particular substances or processes are liable to cause reproductive harm to exposed workers. Clearly, these are questions that we are not competent to determine. Nevertheless, we have proceeded on the basis that workplace exposures significantly contribute to the occurrence of reproductive harm and that, accordingly, questions of regulation and compensation warrant serious examination. We do not think that this starting premise is arbitrary or controversial. There is a substantial and growing body of medical and scientific literature that links the work environment to reproductive outcome.¹⁶

There are a number of issues of perspective that ought to be clarified at the outset. One is the question of burdens and standards of proof. It is common for the scientific community to require that a high standard of proof be met before a proposition is accepted. If we require those who want to protect workers to prove scientifically that exposure is causing or will cause harm, the result will be that workers will bear the risk of uncertainty. They will have to suffer the reproductive impairments first to provide satisfactory evidence of causation. We think this is ethically unacceptable. Although in the past scientists exposed healthy human beings to substances for the purpose of determining whether harm would be caused, today such research would never be approved by an ethics review committee.¹⁷ We cannot see why exposing workers to substances never tested for their effects on human health is more defensible.

We believe that a public health perspective to the question of burdens and standards of proof is the more appropriate one. Because prevention is the central goal, scientific proof that harm is being caused by current exposures should not be required before regulatory action can be taken. Moreover, the burden of proof should be shifted onto the party that wishes to expose people to potentially hazardous conditions. At the very least, this approach would justify regulatory action even where evidence is inconclusive.

A second issue relates to acceptable risk. Because the world cannot be made risk-free, public policy makers are often required to identify some level of risk that is socially acceptable. In the past, a variety of approaches has been used. The first was rooted in the ideal of the free market. Individual workers would decide what risks were acceptable to themselves. Governments and courts only had to give effect to the contracts in which these decisions were embodied. After governments were forced to intervene more actively, they often defined acceptable risk in terms of the industrial average.

We reject both these approaches. The market is characterized by imperfections and imbalances of power, which make individual "choice" and average experience inappropriate starting points for determining what level of risk is socially acceptable. We start from the premise that risks at work should be treated as imposed and not as voluntarily assumed. This is because most workers enter the world of work on conditions not of their choosing and then are denied effective control over their work environment. As a result, if some notion of acceptable risk must be incorporated into public policy, we suggest that it should be defined in relation to the minor risks citizens normally experience on a voluntary basis in everyday activities.

A third issue relates to the question of whether reproductive health warrants greater protection than other aspects of human health. Should workers be able to refuse to work with a potentially hazardous reproductive toxin under circumstances in which they would not be able to refuse to work with a potential carcinogen? Is healthy reproductive function more important than healthy brain function?

We begin our study from the premise that health and safety standards that apply to reproductive hazards should mirror those that apply to other health risks. The adult worker is entitled to the same degree of protection for all bodily systems as is accorded to the reproductive system. Granting preferred status to reproductive or procreative health concerns would suggest that these functions and concerns have a higher priority than others. It would also grant more rights to the workers' prospective or actual fetuses than they themselves enjoy.

The area of reproductive health in the workplace presents in a microcosm all of the ethical dilemmas raised by occupational health and safety generally¹⁸ and is part and parcel of a pressing social problem. The extent of work-related injury is staggering. For example, in 1990, 586 770 claims for lost-time injuries and illnesses were accepted by workers' compensation boards (WCBs) in Canada, and this was a decrease from previous years, which reflects the lower level of economic activity.¹⁹ Moreover, these figures seriously underestimate the true dimensions of the problem, especially with regard to disease, where proof of causation remains an obstacle to claims recognition.²⁰ While scientists debate the dimensions of occupationally induced disease, it is clear that, even according to the most conservative estimates, only a small fraction of

eligible claims are recognized by workers' compensation boards.²¹ The direct cost of these injuries and diseases in 1987 was \$3.5 billion, and, if we use a conservative ratio of 4:1 to estimate indirect costs, the total costs were \$17.5 billion.²² Despite this, workplace injuries and disease have been accepted as an inevitable consequence of industrialized society. While there have been some attempts to moderate the extent of injuries arising out of work, in general they have been accepted as an "occupational hazard." To the extent that ensuring safe workplaces conflicts with the production decisions of private employers, the latter prevail.²³ The problem is that this approach ignores the social costs of workplace hazards. By contrast, we believe that all workers should have a fundamental right to a safe and healthy work environment and that workplaces can be designed to achieve this goal.

The body of the study consists of a thorough and detailed review of the current legal framework for regulating potential and proven reproductive hazards in the workplace and compensation for work-induced reproductive injuries. Our goal is to provide a comprehensive description and analysis of the existing legal regime. In this part we also identify the gaps, problems, and weaknesses in the current legal regimes for regulating, enforcing, and redressing reproductive health and safety and infertility prevention in the workplace. To provide clarity and ease of analysis, we identify the shortcomings in the existing legal regimes as we describe and analyze the case law, legislation, and regulatory practices in each area.

We conclude the study by offering a series of related recommendations identifying the major principles that should shape a coherent policy response to reproductive hazards in the workplace. A functional approach to this exercise is adopted, as any strategy designed to regulate reproductive hazards in the workplace must address the following key elements: equity, prevention, compliance and enforcement, and compensation. We have not tailored our recommendations to make them accord with current mainstream calculations of political feasibility. Instead, we have sought to develop proposals that, in our view, will best achieve the goals of protecting workers from reproductive harm, compensating them when harm results, and doing this within an egalitarian framework. These long-term objectives should provide guidance even while political compromises are struck and partial reforms enacted.

II. Occupational Health and Safety Legislation

A. Introduction

Occupational health and safety legislation has been and continues to be the major instrument through which governments regulate hazards in the workplace. The first Canadian statute of wide application was passed in Ontario in 1884. Its enactment was motivated in part by a fear that

factory work was harming women's reproductive capacity. This concern, however, was only weakly addressed in the law. It placed restrictions on women's hours of work, required a lunch break, and banned them from cleaning machinery while it was in motion.²⁴ Over time, other selective "protective" measures for women were introduced. These were often based on inadequate evidence about women's "special" susceptibility and often applied only in relation to conditions in male-dominated occupations.²⁵ Concern about the effect of work on the reproductive health of women and men is more recent and, as we shall see, is very weakly reflected in current health and safety law.

In theory, early health and safety law relied on a command and control strategy of regulation. The state legislated acceptable levels of risk, and inspectors were appointed to make sure that employers did not exceed these legal limits. Violators were liable to be prosecuted in the courts and fined. In practice, the system operated very differently. Often the standards were defined in terms of reasonableness, leaving substantial discretion to the inspector to determine when conditions were unacceptable. Moreover, the inspectors did not define themselves as factory police. Rather, their primary function was to educate employers about the benefits of a safer workplace and gently persuade them to comply with public standards. Prosecution was a last resort. In effect, the state relied on the employer's internal responsibility system (IRS) to obtain voluntary compliance with health and safety laws.

Dissatisfaction with this traditional approach to health and safety began to boil over in the 1970s. One feature in particular was found to be wanting. Workers had no statutory right to participate in the employers' health and safety decision making. Consequently, a principal change implemented in every Canadian jurisdiction was to reform the IRS by giving workers the right to know, the right to participate, and the right to refuse unsafe work. A second focus of reform was the external responsibility system. Included in this regard was the recognition that potential health hazards needed to be given as much attention as traditional safety concerns.²⁶

Thus, in the following sections, we will examine the reformed internal and the external responsibility systems as they impact on the regulation of reproductive hazards at work.

B. The IRS

1. *The Right to Know*

The foundation for the operation of an IRS, however structured, is that the parties have a right to know about the hazards present in the workplace. Although worker right to know is the main focus of discussion, employer right to know is also an issue that must be, and has been, addressed in legislation. There must be an unbroken chain of communication between the person who produces or imports hazardous substances and agents and its end users, especially the workers exposed to the hazard.

Health and safety laws of the 1970s established a general right to know in the form of requirements on employers to provide workers with all information necessary to ensure their health and safety.²⁷ These general requirements were found to be deficient for a variety of reasons, and a tripartite steering committee was established under the auspices of Labour Canada in 1982 with a mandate to develop a national workplace right-to-know system. This initiative produced the Workplace Hazardous Materials Information System (WHMIS), which was enacted into law through coordinated federal and provincial statutes and regulations.

1.1 WHMIS

The basic requirements of WHMIS are that products identified as hazardous should be labelled, that they should be accompanied by a material safety data sheet (MSDS), and that workers should be trained in the safe use of hazardous materials on the job. For our purposes, it is unnecessary to examine each of these components in detail. Rather, we will focus on how they relate to reproductive hazards in particular.

One further feature of WHMIS should be noted. It applies only to hazardous materials and not to hazardous physical agents such as radiation, noise, vibration, heat, etc. Only Ontario has chosen to include the latter agents in its WHMIS legislation; they are not part of the national system. Also not included in WHMIS are other working conditions such as ergonomics arrangements, working hours, etc., which may also have an impact on human reproduction. To the extent there is a right to know about the hazards of these working arrangements, it must be vindicated through the general "duty to inform" provisions of health and safety statutes, which in the past have proved to be less than adequate.

1.1.1 Identification of Reproductive Hazards

WHMIS imposes no positive obligation on importers, producers, or suppliers of materials to test their products to determine if they are hazardous, but there is a duty to assess substances to determine whether they fall into one of the six classes of hazardous materials established by the regulations. The classes are (A) compressed gas; (B) flammable and combustible material; (C) oxidizing material; (D) poisonous and infectious material (including materials causing immediate and serious toxic effects, materials causing other toxic effects, and biohazardous material); (E) corrosive material; and (F) dangerously reactive material. For the purpose of determining whether a substance is included in one of these classes, suppliers are required to evaluate information specified in the regulations. This includes the results of tests conducted by the supplier in accordance with criteria set out in other parts of the regulation, or the results of tests conducted by others on the particular product or on other products with substantially similar properties.²⁸ If a product has never been tested to determine whether it poses a hazard to reproductive health, nothing in WHMIS would require that such testing be carried out as a condition of its use in Canada.

As a result, the right to know under WHMIS is a limited one. It is a right to know only what the producer knows. This limitation is particularly significant in regard to reproductive hazards because so little is known about the effects of a majority of the substances used in the workplace on the human reproductive system. A fuller-bodied right to know would require importers, producers, or suppliers to generate the data necessary to determine whether a hazard exists and, therefore, needs to be communicated.

Notwithstanding the absence of a positive obligation to test, the regulations do provide criteria for identifying and classifying hazardous materials. Reproductive hazards are most likely to be posed by Class D (poisonous and infectious) materials, and the regulations recognize this; that is, substances that are teratogenic, embryotoxic, or mutagenic, and reproductive toxins are defined as Class D hazards.²⁹ Moreover, criteria are provided for determining whether these hazards are present.³⁰ Thus, where data exist that can be evaluated according to the criteria specified in the regulation, substances posing reproductive hazards will be subject to the WHMIS right-to-know requirements.

1.1.2 Communication

Once a substance has been identified as a hazardous material, information about it must be systematically communicated through labelling and the provision of a material safety data sheet (MSDS). A few comments are in order with respect to these matters as they impact on reproductive hazards in particular.

Information labels must be attached to controlled products. These labels must: contain the name of the product; identify the supplier; indicate MSDS availability; contain the appropriate hazard symbol indicating the class or division of the hazard; include the appropriate risk phrase; and indicate the precautionary and first-aid measures. Although the hazard symbol on a controlled product would not itself disclose that exposure to it poses a risk to reproductive health, the risk phrase on the label would indicate this, and information about the precautionary measures to be taken would be provided.

A MSDS contains more detailed information. It includes the chemical identity and concentration of an ingredient if: the ingredient is listed in the regulations' Ingredients Disclosure List; the ingredient is in a concentration equal to or greater than the one specified there; the supplier has reason to believe the ingredient may be harmful; or its toxicological properties are unknown. There are a number of exemptions from the general requirement to disclose the chemical identity on a MSDS. Aside from the trade secret exemption, there is no obligation to disclose the identity of a hazardous ingredient that is a teratogen, embryotoxin, carcinogen, reproductive toxin, respiratory tract sensitizer, or mutagen if its concentration in a product is less than 0.1 percent. However, it is appropriate to ask whether this exemption is technically justified on the ground that exposure of workers to substances containing such low concentrations of these materials poses no risk in all cases.

1.1.3 Worker Training

In addition to general provisions in health and safety statutes requiring employers to provide instruction for workers to protect their health and safety, special provision is made for workers who work with controlled products. The hazard information received by the employer must be communicated to the worker, and the worker must be instructed in the requirements of the WHMIS system, including the significance of the information provided on labels and in the MSDS. Moreover, workers must be instructed in procedures for the safe use, storage, handling, and disposal of controlled products. In Ontario, the instruction provided by employers with respect to controlled products must be developed and implemented in consultation with the health and safety committee or health and safety representatives. Obviously, where the product is controlled because it is a reproductive hazard, workers exposed to that product should receive appropriate instruction about its safe use.

We will return later to the issue of worker training in relation to the right to participate.

1.1.4 Assessment

It is extremely difficult to assess the general effectiveness of WHMIS and other related statutory provisions to achieve the immediate objective of providing workers with a meaningful right to know. Indications are that it has increased worker awareness of hazardous substances, but that the quality of the information and training received has varied enormously.³¹ We have indicated two areas of concern. First, WHMIS deals with only one category of hazards in the workplace and does not include hazardous physical agents. These are covered by the general duty to inform and train, but, because the content of the duty is not specified, it is less effective. Second, neither WHMIS nor any other right-to-know provision requires that testing be performed to determine whether there are hazards workers should know about. A right to know only what is known is inadequate when we know so little and when there is little incentive for manufacturers, suppliers, or importers to test fully the safety of their products before putting them on the market. At the very least, some mechanism should be put into place to identify substances and agents likely to be harmful and to require that they be tested.

With regard to reproductive hazards, without further study it is impossible to assess the specific effect of these provisions on increasing worker awareness of reproductive hazards in the workplace or enhancing their ability to handle such materials in a way that reduces the risk of harm. At most, we can guess that right-to-know laws operate no better for reproductive hazards than they do for other hazards. They may not operate as well, because the base line of existing knowledge about reproductive hazards is particularly low.

1.2 Canadian Centre for Occupational Health and Safety

For right-to-know laws to be effective, workers and employers must have access to data bases that indicate all known or suspected hazards associated with the substances present in the workplace. Moreover, that information should be freely available. Cost is an especially important consideration for workers who often lack the resources to "purchase" information from commercial sources.

In this regard, the Canadian Centre for Occupational Health and Safety has been an important resource for workers and employers. It has developed its own world-class data bases and provides access to others. It operates a free inquiry service and provides other information services by subscription. Through these services workers and employers can access information on hazards generally and on reproductive hazards in particular.

The centre is currently funded by the federal government, but its budget has been cut and is likely to be cut further, as the government has announced its intent to withdraw or further reduce its support and to require the centre to operate on a cost-recovery basis. The centre has already been forced to charge for some services it formerly provided for free; if the government carries out its plan, it is likely that most of its free services will have to be discontinued. The result is to undermine an important institutional support for worker, employer, and, indeed, community right to know.

2. The Right to Refuse and Other Rights to Self-Protection

2.1 The Right to Refuse

The right to refuse allows workers under certain circumstances to take direct action to protect themselves from being exposed or exposing others to conditions that would endanger their lives and health. Moreover, employers cannot retaliate against workers who exercise this right. As such, it is a strong right, perhaps the strongest right workers enjoy in the IRS.³²

Prior to the enactment of statutory rights to refuse unsafe work, the common law had recognized a right to refuse unsafe work, but it was useless to most workers because the remedies available were too weak. A worker who was fired for refusing to work could sue for wrongful dismissal and, if successful, would be awarded pay in lieu of notice. For industrial or clerical workers, the common law notice period was likely to be quite short. There was no remedy of reinstatement. For workers covered by collective agreements, arbitrators had also recognized that, under certain circumstances, workers could not be disciplined or discharged for refusing to obey an employer's order to perform unsafe work. Essentially, the criteria for the exercise of the right to refuse under collective agreements were that: the employee honestly believed her or his health was endangered; the belief was communicated to the supervisor; the belief was reasonable in the circumstances; and the danger was sufficiently serious

to justify the refusal.³³ Moreover, because arbitrators could order reinstatement in addition to monetary damages for lost pay, it was more likely that workers would be willing to exercise their right.

The statutory right to refuse did little to change the circumstances in which the right could be exercised, but it did extend the remedies available to unionized workers to non-unionized workers and established a clearer process for the resolution of disputes over work refusals. Later in this paper we examine the general parameters of the statutory right to refuse unsafe work and consider the use of this right in relation to reproductive hazards in particular.

Although jurisdictions vary, health and safety statutes in general give workers the right to refuse work when they have reason to believe the equipment they are to use, the physical condition of the workplace, or a breach of the act or regulations is likely to endanger them or another worker. A procedure is then established for informing the employer, conducting an internal investigation (frequently in the presence of worker health and safety representatives), and, if the matter is not satisfactorily resolved, calling an inspector. A worker may be able to continue the work refusal even after the inspector is called if the circumstances would allow the worker to claim that he or she still had reasonable grounds to believe the work was dangerous.³⁴ Employers are prohibited from dismissing, disciplining, penalizing, or intimidating workers who have exercised their rights under the act.

2.1.1 Specific Issues

A few aspects of the statutory right to refuse unsafe work need to be explored in greater detail.

(a) Reasonable Belief

There are at least two components to the determination of the circumstances in which a worker will be found to have had a reasonable belief that work was unsafe. The first is whether the reasonableness of the belief is to be judged objectively or subjectively. In general, adjudicators have adopted an objective standard: "whether the average employee at the workplace, having regard to his general training and experience, would, exercising normal and honest judgment, have reason to believe that the circumstances presented an unacceptable degree of hazard."³⁵ In some jurisdictions, however, a subjective test has been applied to the initial refusal and an objective one to a refusal after the employer's investigation.³⁶

Once an objective test is applied, a second issue arises in relation to the criteria for determining that the belief is reasonable in the circumstances. It is clearly not necessary to prove that the worker's belief in the existence of a danger was correct. More problematic is the significance of the degree of risk the worker perceives. In some jurisdictions, the worker must perceive an "imminent danger."³⁷ This restrictive approach would not permit a worker to refuse work in the face of a hazard whose effects were not acute and immediate. Even where the danger need not be imminent,

there is the question of whether a worker can refuse work because of dangers that have been routinely accepted as normal in the past. Adjudicators have commonly held that refusals to work in the face of such "normal" risks are not reasonable; nor, for that matter, are refusals based on repugnancy, unpleasantness, or fear of minor injury.³⁸ In addition, adjudicators have also been wary about finding work refusals reasonable where "normal" work conditions posed a hazard to a particular worker because of "personal conditions," although there are pressures to accommodate workers with disabilities.³⁹ Moreover, even if it is found that the refusal was justified because of a personal condition, health and safety law does not impose a duty on the employer to accommodate the worker at special risk. A non-retaliatory layoff of such a worker who continues to refuse will probably be justified, although it might be challenged as a human rights violation.

(b) Personal Right

A second feature of the right to refuse is that it is a personal and not a collective right. That is, individual workers can exercise the right only where they personally believe the work poses a hazard to themselves or others. Of course, the worker may be influenced by the beliefs of others, but there is no right to strike in support of other workers who reasonably believe their work is dangerous.

Although a principal goal of the statutory right to refuse was to extend to non-unionized workers the same rights enjoyed by unionized workers, in practice the right is exercised overwhelmingly by unionized employees.⁴⁰ This is true notwithstanding that non-unionized workers can enforce their right through labour relations boards, which are typically vested with the same remedial authority as an arbitrator, including the power to order reinstatement. The reasons for this are not difficult to fathom. Non-unionized workers enjoy less employment security and have fewer resources to support them in disputes with their employer. Empowering workers by granting them statutory rights against their employers can be effective only where workers have reached a base line of security that permits them to exercise their rights safely.

(c) Right to Be Paid

Finally, there is the question of the right to be paid while refusing unsafe work. While employers are prohibited from retaliating against workers for exercising their statutory rights, most statutes do not provide an explicit right to be paid during all or part of the work refusal. An exception is Quebec. There, the statute deems that anyone exercising their right to refuse is at work. As well, where a work refusal results in depriving other employees of work, they are also deemed to be at work and thus entitled to wages.

In Ontario, the statute has been amended and clearly provides that a worker has a right to be paid during the initial investigation. Where no express statutory right exists, the right to be paid depends on whether the

employer has discriminated against the refusing worker. Thus, if there is no alternative work available, the employer may temporarily lay off the refusing worker. Moreover, if workers are laid off because production is stopped as a result of a work refusal or because there is no safe work, they do not have a statutory right to be paid.⁴¹ Thus, workers may face a difficult choice between performing unsafe work and not working and losing pay.

2.1.2 The Right to Refuse and Reproductive Hazards

The frequency with which workers exercise their right to refuse is difficult to gauge. Ministries of labour generally have records only of the work refusals they are called on to investigate. No records are kept of work refusals resolved at the first stage by the parties themselves. In the absence of studies, there is no way of estimating what percentage of work refusals are reported to government. The number of reported work refusals varies as well. For example, in Ontario there were fewer than 100 refusals a year in the late 1970s, but this increased sharply in the 1980s, peaking at 629 in 1988-89. The number dropped off sharply in the following two years, so that there were only 312 refusals in 1990-91.⁴²

The number of work refusals arising out of a belief that work endangered reproductive health is even more difficult to estimate. Government data on the refusals it investigates usually do not contain specific information on the nature of the harm perceived by the worker. This information is available only for cases that result in adjudication arising from a complaint about employer retaliation or where there has been an appeal from an inspector's order that the work is not unsafe. Obviously, these cases constitute an even smaller fraction of the total number of work refusals, and it cannot be safely assumed that they are a representative sample. Nevertheless, this is all we have to go on at this time.

Very few reported work refusal cases involve concerns over reproductive harm. For example, there was not a single case in a table of 49 refusal cases compiled from the Ontario Labour Relations Board Reports and Labour Arbitration Cases up to February 1991 in which the reason for the refusal was indicated to be a reproductive hazard.⁴³ There are two reported cases arising out of the refusal of pregnant women to work at video display terminals (VDTs) — both arose under the Canada Labour Code at a time when it still contained the imminent danger requirement. In both these cases it was determined by inspectors that there was no imminent danger.⁴⁴ It was also held that the worker who continued to refuse after the inspector's report was no longer protected. It is likely that other workers in the federal jurisdiction who refused after this decision would find it increasingly difficult to establish the reasonableness of their initial refusal.

The paucity of reported cases suggests that the right to refuse unsafe work is not used by workers to protect themselves against reproductive hazards. There are a number of reasons that would explain this

reluctance,⁴⁵ most of which are due to the fact that the standards used for judging the reasonableness of a work refusal create a number of problems.

First, because our knowledge of the effects of exposure to numerous substances and physical agents is so limited, it would be difficult to establish that there were reasonable grounds for believing that one's reproductive health was being endangered. The case of VDTs is particularly apt in this regard. A number of epidemiological studies have been conducted on the potential effects of working on VDTs on pregnancy outcome. In most studies, no association has been found between VDT use and spontaneous abortion. However, some studies have found such an association. Exposure to low-frequency magnetic fields, along with psychological stress and ergonomic factors, have been suggested as causal factors. One recent study, for example, found that workers exposed to high levels of extremely low-frequency magnetic fields in early pregnancy may be at increased risk of spontaneous abortion.⁴⁶ Given the degree of uncertainty regarding the hazards of VDT use, it is unlikely women will feel confident about their right to refuse such work. Rather, the right to refuse will most likely be exercised in the face of hazards that are already widely recognized.

Second, if the work refusal is based on a claim of special susceptibility (e.g., a man or woman is planning to conceive a child), then, even if the claim is accepted,⁴⁷ the remedy may not be very satisfactory. In the absence of a right to protective reassignment or compensation in lieu, the worker may be forced to "choose" between accepting the risk or taking a layoff.

Finally, to the extent that it is a woman's reproductive health that is being endangered, she is less likely to find herself in an employment setting where she has the level of security or support necessary to overcome the fear of illegal retaliation. At noted at the outset, women are less unionized than men, and they are disproportionately found in precarious employment situations.

2.2 Protective Reassignment

Only in Quebec do health and safety laws give workers a right to protective reassignment or compensation. In other provinces, workers may have a limited right to "protective" compensation under workers' compensation statutes. The federal government is considering a proposal to give pregnant women a right of protective reassignment under the employment standards part of the Canada Labour Code. We discuss this right in the section on workers' compensation, so only a few comments are made here.

In a sense, protective reassignment legislation provides workers with a different kind of right to refuse unsafe work. Essentially, it deals with situations of special vulnerability. Conditions that are insufficiently dangerous to allow workers in general to refuse exposure may nevertheless be hazardous to particular groups of workers. Rather than requiring the employer to make the workplace safe for the most vulnerable worker, protective reassignment allows the most vulnerable to remove themselves.

Moreover, their right to self-protection is better designed than the right to refuse because they are given a right to reassignment or compensation in lieu. Workers exercising the statutory right to refuse who cannot be reassigned to safe work are not compensated for their wage loss.

The large number of women in Quebec who exercise their right to self-protection while pregnant and breast-feeding contrasts sharply with the small number of women in other jurisdictions who refuse work in the face of the same hazards. Although some women outside Quebec may enjoy a right to protective reassignment under collective agreements, the coverage of such agreements is necessarily limited. The advantage of a statutory right to protective reassignment is thus twofold: on the one hand, the right is enjoyed by all working women, and, on the other, women are prepared to exercise it.

2.3 Unilateral Right to Shut Down

As a general matter, Canadian health and safety legislation does not grant workers or worker representatives the right to unilaterally shut down work perceived to be unsafe pending an investigation by the inspectors. Of course, this result may be achieved indirectly when groups of workers exercise their individual right to refuse unsafe work simultaneously. Depending on how it is defined, a unilateral right to shut down would permit a health and safety representative to make a determination for other workers that work is unsafe and should not be performed, or it would allow workers to make that decision collectively for themselves. The benefit of such a mechanism is that individual workers who fear retaliation from their employer if they refuse unsafe work would not have to bear this burden. A group of workers or a health and safety representative might be easier to protect. Moreover, specially trained representatives might be better able to recognize risks than the average worker.

Ontario recently amended its health and safety laws to provide that a certified worker representative and a certified employer representative could by agreement order dangerous work shut down. As well, provisions were made to grant a unilateral worker right to shut down in exceptional circumstances.⁴⁸ As well, some collective bargaining agreements have given worker health and safety representatives a unilateral right to shut down.

2.4 Summary re Self-Protection Right

The right of workers to protect themselves from exposure to reproductive hazards is underdeveloped and underused, particularly outside Quebec. The right to refuse will be exercised only by workers who are secure enough to risk a confrontation with their employers, and, even then, the outcome is uncertain. The right to protective reassignment or compensation in lieu allows pregnant and breast-feeding women to remove themselves, but it is widely available only in Quebec. Also, men have no clearly defined right to protective reassignment if they are exposed to reproductive hazards at work. Finally, the right of workers or specially trained worker

representatives unilaterally to shut down unsafe work pending inspection by health and safety officials exists only for a tiny fraction of workers.

3. The Right to Participate

The principal vehicle for worker participation in the IRS is through health and safety committees. In some provinces these committees are mandatory for all workplaces over a certain size, while in others they are discretionary or required as directed by a government official. Committees are bipartite, and at least half the members must be worker representatives chosen by the workers or their union. The typical role of the committee is to identify hazardous situations, conduct investigations, make recommendations to the employer for the improvement of health and safety, and be consulted about various measures and programs that may be required by statute.

In some provinces, employers are required by statute to cooperate with the joint committee; in Ontario, the employer is required to respond to recommendations in writing by giving either a timetable for implementation or reasons why recommendations are not being accepted. Except in Quebec, joint committees do not enjoy any power of decision. In Quebec, the committee chooses the physician in charge of health services at the workplace; approves any health program prepared by the physician; decides, within the framework of the employers' program of prevention, the kind of training and information to be provided; and selects personal protective devices. There is no mechanism within the structure of the IRS for resolving disagreements between workers and employers.

As there is nothing special about worker participation in respect of reproductive hazards in the workplace, our discussion of this topic is brief. Joint health and safety committees provide a forum where concerns about reproductive hazards in the workplace can be raised and measures to reduce them discussed. The effectiveness of joint committees in improving health and safety conditions varies enormously, and there are serious concerns about their operation in a significant number of workplaces.⁴⁹

At a structural level, a major problem with the joint committee system is that it is premised on the notion that workers and employers have a common interest in promoting health and safety in the workplace. Sometimes this may be so, but there are other times when their interests diverge. When this occurs, the IRS mechanism becomes a vehicle through which negotiated solutions can be reached. But in this situation, power and its distribution between the parties become significant. Robert Sass, one of the moving forces behind the reform of Canadian health and safety laws in the 1970s, has criticized the Canadian IRS because of its failure to provide workers with the "strong rights" necessary to counterbalance the employers' superior economic power and control over the enterprise.⁵⁰

Although there is little explicit recognition of the significance of the power in the workplace, there is widespread acceptance of the view that the IRS operates more effectively in union than in non-union establishments.⁵¹

This is based on an implicit recognition that, in the absence of a basic level of employment security, workers are powerless and, indeed, afraid to act. Beyond this basic level of security, workers require bargaining leverage within the IRS to influence employer decisions with respect to issues on which the parties disagree.

Because of the power imbalance in the IRS and the lack of an adequate dispute resolution mechanism, its relation to the external responsibility system must be examined to evaluate the overall effectiveness of health and safety regulation. In particular, it is important to understand the extent to which the external responsibility system monitors, supports, and, if necessary, supersedes the IRS. We return to this issue in the context of the discussion on the role of external enforcement.

Beyond the relationship between the internal and external responsibility systems, analysis at the institutional level discloses other problems. One study in Ontario revealed that despite their perception of hazards in the workplace, workers rarely made use of their rights. Lack of knowledge about their rights and lack of self-confidence, especially about the legitimacy of their experiential knowledge of the links between work and ill health, were seen to be major obstacles to effective worker participation.⁵²

Training workers to increase their ability to participate has been a major objective of the Canadian labour movement and has received financial support from government and WCBs in this effort. Tens of thousands of Canadian workers have been through programs designed to familiarize them with their rights and basic principles of health and safety. The extent to which education about reproductive hazards is incorporated into training programs varies. For example, the Ontario Federation of Labour offers a basic 30-hour certificate program consisting of seven required and three optional courses. One of the optional courses is on reproductive hazards for which a useful and clear primer on the subject has been produced.

Employers are also involved in various training programs, as are governments. This may include the dissemination of information on various hazards. In Alberta, for example, non-binding medical guidelines have been issued respecting medical assessment of the pregnant worker, workplace hazards affecting fertility, and medical monitoring of workers exposed to lead. However, these publications appear to be aimed at health professionals.⁵³

As a general matter, workers are not entitled to health and safety training at full pay during working hours. However, some provinces, including Ontario and Quebec, do make provision for certified or worker representatives to receive training as part of their paid work.

Finally, we might ask whether joint committees are likely to be less effective in dealing with reproductive hazards than they are with other hazards. The answer is necessarily speculative, but this might be the case, as experience suggests that joint health and safety committees are better at dealing with safety than with health. In part, this relates to the fact that safety hazards are easier to detect and is because more training is required

for workers to feel they have the technical competence to raise questions about health practices in their workplaces. Also, safety concerns are often easier to rectify through housekeeping and other relatively inexpensive measures. Eliminating, reducing, or controlling health hazards may require more extensive measures, including expensive changes to the production process. Moreover, because health and safety committees need not be consulted by employers at the planning stage, they will often find themselves trying to correct or minimize hazards built into the employer's technological and production decisions. Reproductive hazards are usually more health- than safety-related, and thus their control by joint committees is likely to suffer. Finally, to the extent that knowledge about reproductive hazards is less well developed and less widely dispersed than knowledge about other health hazards, the odds that effective preventive action will be taken through the IRS are diminished.

C. External Responsibility System

1. ***Regulating Hazardous Substances, Agents, and Conditions***

A variety of approaches could be adopted by an external agency with a mandate to protect workers against harm from hazardous substances, agents, and conditions. These include: (1) reducing the use of hazardous materials in the workplace through front-end controls aimed at preventing hazards from being introduced into the workplace (typically this would be linked to testing requirements imposed on the party seeking to introduce a new substance or agent) and through measures requiring testing and, ultimately, the removal of agents identified as hazards from the workplace; (2) designing controls that require specified measures to be taken to reduce worker exposure to hazards in the workplace; and (3) designing exposure controls that stipulate the maximum level of exposure a worker can receive. The third approach has been the dominant one adopted by Canadian health and safety regulators with respect to hazardous substances. The second approach has been used occasionally with respect to some health and safety hazards. The first approach is rarely used at all.

Our focus in this section is on the regulation of hazardous substances and physical agents with particular regard to reproductive hazards.

1.1 *Use Reduction Measures and Testing*

The objectives of use reduction measures are to prevent the introduction of new or more serious hazards into the workplace and to reduce or eliminate hazards already present. The first objective could be achieved by requiring persons seeking to introduce new substances, agents, processes, or conditions to get prior clearance from a regulatory authority. This clearance would be granted only after the applicant had provided sufficient information to determine the substance was unlikely to be harmful to users. Testing of various sorts would have to be conducted to generate the information necessary for a decision. As for substances already in use,

provisions could be made to require that they be tested if their properties are unknown and, if they pose hazards to human health, that they be removed.

1.1.1 New Substance Screening — Preclusion

As noted in relation to right to know, WHMIS does not require testing of substances currently in use or of new substances. There are provisions, however, in the Canadian Environmental Protection Act (CEPA) that, when implemented, will create a national system for screening substances new to Canada.⁵⁴ Under this statute, it is illegal to manufacture or import new substances until after information specified by regulation has been provided to the minister and a period for assessment has expired. If after assessment it is suspected that a substance is toxic, the minister of the environment may permit manufacture or import subject to specified conditions, prohibit manufacture or import, or request further information.

Regulations to implement these provisions are being drafted but have not yet been promulgated. The most recent draft, discussed at a stakeholders' meeting in December 1991, sets out the notification requirements. Of particular interest are the amount and kind of testing that will be required. This varies depending on the amount of the substance to be imported or manufactured and on a number of other factors related to its use (e.g., site-limited intermediary, export, etc.). For those substances under Schedules I and IV, no testing is required. For those under Schedule II, data from one acute mammalian toxicity test and one *in vitro* mutagenicity test must be provided. For those under Schedule III, data from two acute mammalian toxicity tests, one repeated-dose mammalian toxicity test of at least 28 days' duration, and two different *in vitro* and one *in vivo* mammalian tests for mutagenicity must be provided.

It appears that the proposed testing requirements would not be adequate to determine the teratogenic effects, if any, of new substances. Competent experts, however, should examine the protocols and make appropriate recommendations to ensure that reproductive health risks are not overlooked in this important initiative.

What remains unresolved in the scheme is what measures will be taken when it is suspected, on the basis of the assessment, that a substance is toxic. The minister is given a range of options but no guidance, beyond the general statement in the preamble, on how to exercise power. Banning may not always be the preferred alternative, especially where a new substance is being used to replace an even more toxic substance already in use. Nevertheless, if the goal of risk reduction or elimination is to be achieved, then the formulation of orders must be driven principally by that concern and not by economic considerations.

A number of provinces also have provisions in their health and safety statutes that could be used to prevent new hazardous substances from being introduced into the workplace or to eliminate current ones. Ontario has mandatory pre-market notification requirements for the manufacture,

distribution, or supply of new biological and chemical agents.⁵⁵ When an occupational health and safety director is of the opinion that the new agent may endanger the health and safety of workers, the director is required to order that an assessment be done, at the manufacturer's or distributor's expense. This could include a requirement that testing be performed. The statute does not specify what actions could be taken if the assessment disclosed that the use of a substance would likely endanger the health of workers, but presumably knowledge of the hazard would allow the director to issue workplace-specific orders under Section 33 to prohibit the substance, limit or restrict its use, or impose conditions on its use. In addition, steps could be taken to designate the substance by regulation.⁵⁶

To date, a total of 819 notifications have been received, or an average of 68 each year. Ministry staff review these notifications to determine whether an employer assessment is required. No employer, however, has ever been ordered to conduct an assessment because of a specific concern about potential reproductive hazards. Clearly, this mechanism is not as well designed as the proposed New Substances Notification Regulations, which require testing data to be provided to the ministry so that it can conduct its own assessment on the basis of adequate information. In Quebec, the Commission de la santé et de la sécurité du travail (CSST) has the power to institute a regime of mandatory pretesting but has not done so.⁵⁷

1.1.2 Testing and Eliminating Hazards in the Workplace

While only a few provinces have the power to regulate the entry of new substances and agents into the workplace, they all have power to regulate hazards once they are present. On the whole, this power is exercised by establishing maximum exposure levels, as examined below. Here, we want to discuss briefly the extent to which there is authority to order testing and to prohibit the use of substances and agents already in use.

Only a few provinces have the power to order the employer to perform toxicity testing on substances already in use in the workplace. For example, in Ontario inspectors may require employers to perform tests at their own expense to determine whether a substance is hazardous by those criteria.⁵⁸ More generally, inspectors in most provinces may perform testing themselves or obtain expert assistance to conduct tests.

It is doubtful whether inspectors are vested with the power to prohibit the continued use of substances or agents demonstrated to be harmful. Where they determine that an unlawful hazard exists, they can issue compliance orders and, in most provinces, stop-work orders if the violation poses an immediate hazard to workers. It is unlikely, however, that, in the absence of an express statutory provision or regulation prohibiting the use of a substance, an inspector would have the authority to issue an order banning it.

In Ontario, an occupational health and safety director is given the power to prohibit the use of a toxic substance even though there is no

regulation in force imposing such a ban. The order of the director, however, binds only the workplace to which it is directed. In Quebec, a similar power is given to the CSST, but it can issue only an order of general application.⁵⁹ In Ontario, this power is infrequently used and has never been used to prohibit a substance because of the hazards it posed to human reproduction.

All provinces have the power to make regulations controlling toxic substances and hazardous agents in the workplace. This includes the power to prohibit their use. As we indicated earlier, prohibitions are almost never used and, to our knowledge, have never been used in regard to reproductive hazards.

Finally, we should indicate that the federal jurisdiction has adopted a mandatory substitution policy. Under its provisions, employers are forbidden to use a hazardous substance in the workplace if it is practical to substitute a non-hazardous or a less hazardous substance.⁶⁰ The extent of the enforcement of this regulation and the question of whether it has ever been used to reduce the presence of reproductive hazards in the workplace require further study.

1.2 Design Control Regulations

Design control regulations are an option that arises *after* it has been determined that the use of hazardous substances, agents, conditions, and/or processes is permitted. They represent another possible strategy for regulating the risk arising from the presence of hazards in the workplace. In particular, design control regulations give employers clear directions about control measures that must be adopted. These might include provisions requiring isolation, enclosure, ventilation, work practices, etc. Unlike exposure limits or performance regulations, design controls do not specify a measurable result that must be achieved while leaving it to the employer to determine how to do so. Rather, they focus on the employer's work practices.

Such regulations are used to some extent in construction, mining, and industrial safety. Their use in regard to toxic substances, however, has been successfully resisted notwithstanding that such regulations have some attractive features.⁶¹ In particular, design regulations are easier to enforce because non-compliance often can be detected visually. To the extent that engineering controls that remove the risk at source are selected, the level of protection is likely to be higher than would be the case with exposure limits. Moreover, given the level of uncertainty about the effect of exposures to substances in isolation and in combination, and the challenge of developing appropriate exposure levels for the vast number of chemicals and chemical combinations present in the workplace, generic design regulations might be a preferable option.

Resistance stems from a variety of concerns, including the fact that design standards constitute a greater infringement on *managerial prerogative* than performance standards. Performance standards allow the

employer to determine how to achieve compliance, while design standards specify what measures are to be taken. Moreover, it is argued, design standards introduce rigidities that inhibit innovation and, in the long run, may result in higher costs and lower levels of safety. Also, given the wide range of circumstances in which hazardous substances are used, it may be extremely difficult to develop appropriate design standards.

To the extent that toxic substance regulations in Canada contain any design specification, they consist of extremely general stipulations and, perhaps, a requirement that personal protective equipment is to be used only when engineering or other control measures are ineffective. This has been done in Ontario, for example, in its lead regulation.

1.3 Performance Standards/Exposure Limits

The dominant approach to regulating hazardous substances and agents in the workplace is to allow employers to decide what to use and how to use it and to impose exposure limits only if it is subsequently demonstrated that workers are harmed as a result. In other words, regulation through performance standards tends to be reactive. It allows employers maximum freedom in deciding what and how to produce and in determining how to reduce to legally prescribed levels exposure to the risks they have introduced.

The adequacy of this approach, especially when used as the dominant one, is doubtful. The sheer volume of potentially harmful substances and agents used in the workplace presents a formidable challenge to regulators. The task becomes overwhelming when one considers all the possible combinations and their potential interactive and synergistic effects. There is frequently great scientific uncertainty about whether exposure is harmful and, if it is, the level of risk at different exposure levels. The problem is particularly large in regard to reproductive harm because of how little we know. The question of who bears the burden of uncertainty is a crucial issue in the standard-setting process, as is the question of the level of risk the regulations should aim to achieve. Typically, only airborne exposures are regulated, leaving other routes of exposure (e.g., skin contact, ingestion) unregulated. Exposure limits are typically expressed in time-weighted averages and can be enforced only through expensive air sampling.⁶²

Rather than elaborate on the problems with standard setting generally, we focus on the use of this approach to regulate reproductive hazards. It is necessary, however, to broach a number of these more general issues along the way.

1.3.1 Adopted Standards

A large number of exposure standards in Canada are set by reference to the threshold limit values (TLVs) of the American Conference of Governmental Industrial Hygienists (ACGIH), which, despite its name, is a private voluntary organization composed of government and industry officials and academics. Examples of the use of ACGIH TLVs include Nova Scotia, which adopted the ACGIH TLVs as legally enforceable standards in

1976. Ontario followed the same course in 1986.⁶³ Other provinces, such as British Columbia, simply use the ACGIH guidelines without formally adopting them as regulations.

The wisdom of relying on ACGIH TLVs has been seriously questioned by a number of recent studies disclosing undue corporate influence on the development of these standards. In addition, the scientific and medical information upon which many standards were set has been shown to be inadequate, and it has been demonstrated that TLVs were poorly correlated with the documented studies indicating adverse health effects. The same study showed, however, that they are highly correlated with exposure limits reported in industry at the time the limits were adopted.⁶⁴ As a result, the validity of the claim in the introduction to the ACGIH TLV documentation book that "these values represent conditions under which it is believed nearly all workers may be repeatedly exposed day after day without adverse health effects" is doubtful.⁶⁵ Indeed, another study of ACGIH's approach to the regulation of carcinogens concluded that their recommended exposure levels are determined using a comparative risk approach premised on the belief that occupational mortality in average-risk industries is acceptable.⁶⁶

The extent to which the TLVs have been drafted to protect reproductive health is difficult for us to determine. A number of brief observations, however, might be of some use. First, ACGIH acknowledges that exposure at its recommended levels will not protect all workers. It recognizes that individual susceptibilities will vary and that it has not recommended exposure levels to protect the most sensitive. To the extent that some workers are more sensitive in particular phases of the reproductive cycle (e.g., men or women planning to conceive or pregnant women), it is likely that exposure at ACGIH TLVs will not protect them adequately.

Second, as more research is done on reproductive hazards, they are increasingly referred to in the TLV documentation. For example, the documentation makes reference to any animal studies indicating reproductive or developmental effects. It also refers to genotoxicity studies and any human studies indicating reproductive hazards. This is a positive development.

However, it is often difficult to determine how responsive the TLV is to the hazards suggested by the documented studies, particularly when reproductive risks are indicated by animal studies. For example, with respect to benomyl, the documentation notes that two recent articles cited seven animal studies that reported reproductive or developmental effects. The ACGIH recommended an exposure level of 10 mg/m³ despite the fact that the National Institute of Occupational Safety and Health (NIOSH) had rejected this level of exposure as inadequate to protect against reproductive effects. In the case of carbon disulphide, ACGIH notes reports of reproductive effects in animal and human studies. Yet, it maintained its recommended exposure limit at 10 mg/m³ despite the fact that the Occupational Safety and Health Administration (OSHA) had reduced its limit to

4 mg/m³ to protect against carbon disulphide's cardiovascular, neurological, and reproductive effects, and it would have gone lower but for evidence indicating it was not feasible to do so.

In sum, it cannot be safely assumed that ACGIH TLVs protect workers against health impairment generally. It is even riskier to assume that ACGIH TLVs protect workers against reproductive harms.

1.3.2 Made-in-Canada Standards

Canadian occupational health and safety regulators have produced few of their own standards. By and large, they adopt ACGIH's. Below, we examine a few of the local efforts that responded, at least in part, to reproductive hazards.

(a) Lead in Ontario

The Ontario lead regulation is one of the most controversial and widely commented on occupational health standards promulgated in this country. The reason for this is that the Code for Medical Surveillance adopted a lower blood lead action level for women of childbearing years to safeguard the developing fetus. The general rule was that workers had to be removed from lead exposure when the lead levels in their blood exceeded 0.70 mg/L, but for fertile women the level was lowered to 0.40 mg/L. Those who were removed, however, were entitled to workers' compensation. In addition, women were advised to notify their employers if they became pregnant; a physician was then to advise the worker and the employer whether the worker should be removed from further exposure to lead.⁶⁷

The development of the regulation is thoroughly discussed by Swinton and Tuohy.⁶⁸ In brief, initially the Ministry of Labour's proposal was to adopt the ACGIH guideline as a regulation on the basis that the evidence of impairment to workers (including reproductive harm) at the level specified in the code was inconclusive. Labour reacted negatively and pointed to a number of subclinical effects and adverse effects on the male and female reproductive systems, including teratogenic and fetotoxic effects. The ministry subsequently accepted the validity of concerns about lead's teratogenic effects and adopted the code's two-tier action levels described above. As to the other concerns, including the effect of lead on the male and female reproductive systems, the minister concluded that evidence was too inconclusive to warrant further regulatory action.

In adopting this course, not only did the ministry fail to provide any opportunity to discuss and debate the implications of its choice of two-level removal, it also failed to consider whether it would be feasible to improve protection for all workers. Clearly, the ministry was placing the burden of proof on those who wanted to reduce current levels of exposure and was not accepting that the burden had been discharged by animal test data indicating a risk.

The extent to which the regulation has resulted in women being removed from lead exposure is unknown. It is interesting to note that New Brunswick, which also has lower lead action levels for women of child-

bearing years, reports that there are no instances in which it has been applied. Whether this is because women are not being employed in jobs where they are exposed to lead or because exposure levels have been reduced to the point where the lower action level is not reached is not known.

(b) **Radiation in the Federal Jurisdiction**

The history of special protection for women in this area begins in 1960 when the Atomic Energy Control Board first promulgated health and safety regulations for atomic energy workers.⁶⁹ Employers were prohibited from employing persons under 18 years of age, pregnant women, and anyone else whose health was such that employment as an atomic energy worker would be undesirable. Permissible exposure levels that did not discriminate between men and women were also established.

It was only in 1974 that the exclusion of pregnant women was ended and replaced by exposure levels that differentiated among workers generally, women of childbearing years, and pregnant women. For workers generally, the permissible dose was 3 rem per quarter and 5 rem per year. For fertile women, the quarterly exposure was reduced to 1.3 rem while the annual dose remained at 5 rem. However, the dose to the abdomen was not to exceed 0.2 rem for each two-week period and, once an employer knew that a woman was pregnant, the permissible dose was not to exceed 1 rem for the remainder of the pregnancy.⁷⁰ To achieve compliance, employers chose to exclude women of childbearing years. This resulted in human rights complaints and lobbying and led to further amendments to the regulations in 1985. The special protection for fertile women was removed; in its place, an obligation was placed on women to inform their employers of their pregnancies. This triggers an obligation on employers to ensure that exposure does not exceed 1 rem for the remainder of the pregnancy and does not accumulate at a rate of more than 0.06 rem every two weeks.⁷¹

The extent to which these regulations have resulted in the removal of women from the workplace has not been ascertained. In this regard, however, it is interesting that New Brunswick — which, like many other provinces, has radiation protection standards that set special limits for fertile women — reports that no women have been removed as a result.

(c) **Discussion**

As indicated initially, most exposure levels are derived from the ACGIH recommendations. Of the made-in-Canada standards, aside from lead and radiation, few make explicit provision for reproductive hazards. Indeed, the only other substance regulated, in part, as a reproductive hazard is mercury in Ontario. Instead of adopting a two-level removal approach, the ministry simply noted in the Code for Medical Surveillance that "exposure of females capable of bearing children should be kept to a minimum."⁷²

In the few instances when health and safety officials have regulated substances because of their reproductive hazards, they have done so to

protect the fetus. Moreover, protection was to be achieved by lowering exposure levels not for all workers, but just for the bearer of the fetus (i.e., the woman). Critics have rightfully pointed to the equality concerns raised by such a strategy. It gives employers an incentive not to hire women because of the potentially higher monitoring costs that may be incurred if they become pregnant, or because they may have to be removed, thereby disrupting work arrangements (hiring men would not pose these problems). A further disincentive will arise if employers are required to bear any of the costs of compensating women removed from work.

More generally, the focus on the fetus tends to reinforce the idea that it has interests distinct from the mother, and that the state and the employer have a legitimate interest in intervening in the mother's life to protect the fetus. It tends to divert attention away from the role of the employer in creating the hazard in the first place. To the extent that regulations concern themselves with the reproductive health of parents, it is only the woman's vulnerability that seems to be the object of concern. This ignores men's reproductive role and the emerging, although non-conclusive, evidence that workplace exposures of fathers may result in congenital abnormalities in offspring.⁷³

The focus on discrimination also has diverted attention away from an equally compelling concern: the failure of regulations to adequately protect the reproductive health of men and women. Regulators start from the presumption that current exposure levels in major industries are acceptable unless the contrary is proven. Because of a lack of data on the effects of exposure to most substances on human reproduction, it is difficult to meet the implicit burden of proof, leaving workers to bear the risk of uncertainty. We have discussed this concern in relation to the ACGIH TLVs. Here we briefly indicate the significance of this for local regulations.

We noted that with respect to lead, Ontario took steps to protect the fetus but did not find the evidence of harm on the adult reproductive system sufficiently convincing. Yet, the World Health Organization has recommended a 0.40 mg/L limit for men, and the United States and United Kingdom have recommended public health standards at the 0.25 mg/L level.⁷⁴ In regard to mercury, the ministry indicated that it lacked sufficient information on the effect of chronic low-level exposure on children and for that reason had not recommended a lower removal level for pregnant women.⁷⁵ In respect of the vinyl chloride standard, the ministry considered the evidence indicating an association between exposure and congenital abnormalities in offspring insufficient to warrant regulatory action.⁷⁶ Ontario has also regulated other known or suspected reproductive hazards, including arsenic, benzene, and ethylene oxide. No efforts have been specifically addressed to prevent reproductive harms resulting from exposure to these substances.⁷⁷

In sum, the current approach to standard setting in respect of reproductive hazards is deficient in two significant ways. First, it cannot be safely assumed that the current standards protect reproductive health.

Second, to the extent that reproductive hazards result in regulatory action, equity concerns do not receive sufficient attention.

1.4 Some Recent Developments

There are some changes taking place with respect to how health and safety standards are developed and the principles that should govern them. For example, Alberta recently put in place a process for regular review and amendment of occupational exposure limits that goes beyond the routine acceptance of values recommended by ACGIH. The process involves business, labour, and academic input and requires consideration of all potential health effects, including fetotoxicity and reproductive damage. The review group is moving toward a philosophy favouring the adoption of limits that offer protection to the most susceptible sector of the workforce. However, the regulations have not been altered to address this point specifically.

Recent developments in Ontario should also be noted. In response to labour's dissatisfaction with the designated substance regulation process, in 1987 the government created the Joint Steering Committee on Hazardous Substances in the Workplace. It is a bipartite committee chaired by a representative of the Ministry of Labour. It does not have the power to promulgate regulations, but any recommendations it makes to the government would be given great weight. Agreement has been reached that exposure limits should be lowered to the lowest level set by countries that establish standards after a reasonably thorough review of the scientific literature and that involve labour and employers in some meaningful way in the process.⁷⁸ To the extent that other acceptable jurisdictions have established standards that are more protective in regard to reproductive hazards, these changes should produce beneficial results. A second initiative is aimed at developing generic regulations requiring specific design controls to eliminate or reduce exposures. There is also discussion about including a duty to provide workers with extra training in the use of reproductive hazards.

2. Enforcement

Good but unenforced health and safety standards are less than worthless, since they create a public illusion that something is being done when in reality workers' lives and health remain at risk. Historically, health and safety regulation has been exceptionally prone to disjunctions between law on the books and law in the workplace.⁷⁹ Despite the reforms introduced by the second wave of health and safety legislation in the 1970s, the problem has not been resolved.

This is not the place for a thorough review of enforcement issues and the large literature it has generated.⁸⁰ The best we can do is make some general observations and draw attention to the enforcement of provisions aimed at reducing reproductive hazards in the workplace.

The first point is that enforcement resources are extremely scarce. While we do not have national data, statistics from Ontario are probably representative of the situation in other jurisdictions. In 1990-91 there were

296 inspectors in the province for 286 000 establishments. Slightly fewer than 57 000 inspections and 7 574 investigations were conducted that year. Since some are inspected and investigated more than once, the total number of establishments seen by an inspector is less than these figures suggest.

In any event, it is clear that the probability of a workplace being randomly inspected in any given year is low, unless the employer has been singled out for special attention by the enforcement branch. A review of the act's administration in Ontario recognized this problem and called for an increase in the complement of inspectors. More inspectors were hired, but the complement has been decreasing in recent years.⁸¹

A second and related point is the quality of inspectors. How well trained are they to carry out their responsibilities? This is particularly important for enforcing the law as it relates to toxic substances and harmful physical agents requiring special expertise. In most provinces, inspectors do not have university-level education in science and receive little training on human biology and the effect of toxic exposures on organ systems. They receive little or no instruction specific to reproductive hazards. The ministry often makes special services available to the inspector, but these services (e.g., the number of occupational hygienists or other persons qualified to perform the required testing and assessments) are limited. This problem is exacerbated by the design of exposure limits requiring specialized testing to determine if there is compliance.

Given these limitations, the question of how enforcement resources are used is crucial. The dominant approach to occupational health and safety enforcement in Canada can be described best as one of gentle persuasion. The principal strategy for securing compliance is to have inspectors facilitate the operation of the IRS. They typically do this by educating employers and workers about their rights and responsibilities, checking to see whether the joint health and safety committee is meeting and dealing with issues, and investigating complaints.

Their more coercive powers, including the power to issue compliance orders, stop-work orders, or initiate prosecutions, are infrequently invoked. Again, we do not have national data to demonstrate this point, but Ontario's case is illustrative.

In 1990-91, 58 970 orders were issued, or about one per inspection. However, where causation is unclear (as will often be the case with respect to reproductive hazards), inspectors may be hesitant to take even this step. Where evidence of causation is inconclusive, no action will be taken. Thus, for example, when the Ontario Public Service Employees' Union became concerned about the incidence of spontaneous abortion among women working on VDTs, the inspector refused to issue an order, and this was upheld on appeal.⁸² Of the orders issued, 3 095 or about 5 percent were stop-work orders. A total of 1 545 charges were laid. Put differently, only 1 out of every 38 violations of health and safety laws detected by inspectors resulted in a charge being laid. Moreover, only about one-third of the

charges laid were actually prosecuted. Thus, less than 1 percent of all detected violations led to prosecutions. Even with a high success rate, the number of employers actually convicted is thus further reduced, and the average fine on conviction was \$5 626.⁸³ Data on enforcement in Quebec indicate a similar pattern.⁸⁴

Prosecutions are usually launched only when a worker is seriously injured or killed as a result of an accident caused by the employer's breach of the law. This is significant with respect to protecting workers from reproductive hazards because, in most cases, the injury is non-traumatic. It is, therefore, not surprising that no health and safety branch in Canada could recall ever launching a prosecution of an employer because of a reproductive hazard in the workplace.

One province, British Columbia, uses a somewhat different approach to sanctioning, although persuasion is still its primary enforcement strategy. Because the WCB has jurisdiction over health and safety enforcement, it can use its power to impose penalty assessments for observed hazards to induce employers who have not been persuaded to correct breaches of health and safety laws to comply. There are advantages to administrative sanctions: the courts do not become involved, and the agency can focus on the presence of a risk rather than on the resulting harm. This approach apparently leads to more frequent sanctioning, but it is not clear whether compliance levels are higher as a result.⁸⁵

On the basis of this brief survey, it seems that, generally, external enforcement as currently conducted does not have a serious deterrent effect. But health and safety officials would argue that, as implementation programs are not premised on a deterrence model, this is not a fair basis for judging their success. Rather, a self-compliance model has been adopted; thus, we must examine the nexus between the external responsibility system and the IRS to make a fair assessment.

The issue is too large to explore here, but we might consider some aspects of it that are particularly relevant to reproductive hazards. From the framework developed here, the crucial issue is the extent to which the state is prepared to lend its weight in support of worker demands that the employer has not voluntarily met in the IRS. In theory, any failure by the employer to take positive measures with respect to conditions violating health and safety laws should be met with an order from the inspector or a state-imposed sanction. Yet, at least in Ontario, there have been widespread complaints that because inspectors are instructed to give primacy to their role as facilitators, they are hesitant to shift to an enforcement mode.⁸⁶ Rather, the emphasis will be on getting the parties to agree to a solution between themselves.

This tendency will be even stronger when the dispute relates to a condition that does not clearly constitute a violation of the act. Thus, for example, if there was a disagreement about the appropriate control measures to protect workers from a toxic substance, it is unlikely the inspectors will intervene decisively. Swinton, in discussing the role of

Ontario inspectors in enforcing designated substance regulations, observed that, "definitive rulings on policy issues, such as the choice of the 'better' control program, are likely to be avoided, for such a ruling would require decisions about capital expenditures, assignment of the work force, and feasibility of changes in production processes, and the OHSA [Occupational Health and Safety Act] and regulations were not designed to remove the final responsibility for such decisions from management."⁸⁷ Because protecting workers from reproductive hazards is likely to require precisely these kinds of changes, the unwillingness of the inspectorate to intervene will be particularly significant.

Finally, external enforcement should be strongest where the IRS is weakest. Yet it is not clear that this is so. Indeed, there is evidence that scarce enforcement resources are disproportionately allocated to unionized workplaces, which on average are likely to have a better-functioning IRS than the non-union sector.⁸⁸ The reason for this is that much of the allocation is demand-driven, and unionized workers are much more likely to call on the resources of the ministry to resolve a dispute with their employer because of their greater willingness to exercise their legal rights. Not only does this have an adverse impact on non-unionized workers, but, because women are disproportionately found in the non-union sector, they are less likely to benefit from external enforcement.

D. Summary and Conclusion Concerning Barriers

A fundamental starting point is that it is extremely unlikely that workers' reproductive health can be better protected than their health in general. To the extent that health and safety regulation fails to protect workers generally, it will also fail to protect their reproductive health. There is also little reason to give reproductive health a higher priority than, say, mental health. It is important, however, to assure that reproductive health is considered an integral part of human health and is not ignored or inadequately protected in occupational health and safety regulation. Moreover, to the extent that the protection of reproductive health requires special measures, adequate provision must be made.

Our general assessment is that current occupational health and safety regulation fails adequately to protect workers' health in general and that it is especially weak in respect of reproductive health. While there has been some improvement in regulating particular physical hazards and hazardous substances, little or no recognition has been given to the impact of work organization and design on worker health generally and reproductive health in particular.

Worker right-to-know laws will always be inadequate if they are not linked with a duty to test. This is especially true in the area of reproductive hazards, where little is known about the effect of exposure to a large number of substances, physical agents, and other work conditions (e.g., stress). The right to know what is already known cannot therefore provide

workers or employers with the information they require to take appropriate action in regard to agents that are reproductive hazards. Subject to the above limitation, WHMIS is a positive development that does include reproductive hazards in its identification and communication requirements. It covers only hazardous substances, however, and not other sources of risk, such as physical agents and work arrangements, which may also adversely impact on reproductive health.

The right to refuse unsafe work is not an effective means by which workers can protect themselves from reproductive hazards in the workplace. Aside from general inhibitions limiting the exercise of the right, such as fear of employer retaliation, the uncertain dimensions of the risk that exposure poses to reproductive health will make it difficult for workers to feel certain their beliefs will be found to be reasonable. Moreover, to the extent that exposure is hazardous only to workers who are especially vulnerable, a work refusal may not result in any changes to the workplace. Human rights legislation, however, may result in the imposition of a duty to accommodate.

Protective reassignment with a right to compensation if no safe work is available is far superior to a right to refuse. But, if this is claimed by pregnant workers, it is important that the process for obtaining protective reassignment is expeditious and the criteria are clear; otherwise, difficulties arise with its implementation, resulting in its being underused. This seems to be the case with respect to the section of Quebec's law giving workers a general right to protective reassignment.

The success of joint health and safety committees varies greatly. Moreover, their ability to deal effectively with reproductive hazards in the workplace is likely to diminish, since reproductive hazards are difficult to detect and likely more expensive to control. Workers need more training and influence to change the situation.

The principle of pretesting new substances prior to their introduction into the workplace to determine whether they are reproductive hazards has yet to be adopted as a component of occupational health and safety regulation. To an extent, this will be remedied when the New Substance Notification Regulations are promulgated under CEPA. The principle that all substances currently in use should be tested to determine whether they pose hazards to human reproduction has also not been adopted, nor has the power to order testing on an ad hoc basis, where it exists, been exercised frequently. The powers to ban substances and order the substitution of safer ones and to promulgate design control regulations requiring employers to adopt particular precautions when using hazardous substances have also not been exercised.

Exposure limits are primarily derived from ACGIH TLVs. The extent to which these limits protect the reproductive health of exposed workers is suspect and requires further investigation.

A few made-in-Canada exposure limits are designed to protect the fetus by removing pregnant women or women of reproductive capacity from

exposure at lower levels than the ones permitted for workers generally. This creates incentives to discriminate. Moreover, there is no evidence that the lower exposure levels could not be applied to all workers. When setting local exposure standards, regulators have not always responded appropriately to evidence of reproductive harm. For example, the Ontario lead regulation may inadequately protect men's and women's reproductive health. In addition, the resources devoted to enforcing occupational health and safety laws are inadequate. Because of the lack of resources and the self-compliance model adopted by regulators, external enforcement does not represent a serious deterrent. As far as is known, no employer has been charged or prosecuted for exposing workers to reproductive hazards. Moreover, workers who cannot obtain improvements to health and safety conditions through the IRS are unlikely to obtain significant support from the external responsibility system. In particular, workers who need help the most may not be getting it. This is of particular concern to women, who are disproportionately found in precarious employment situations.

III. Workers' Compensation⁸⁹

A. Introduction

The workers' compensation system serves three functions. Its primary one is to compensate workers for their work-induced injuries or diseases regardless of fault on the part of the employer, and generally without regard to fault on the part of the worker.⁹⁰ It is also the exclusive remedy for such injuries. The right of injured workers to sue their own employers, other employers in the province, and co-workers is generally barred by statute. Exceptions to this rule are discussed in the section on tort liability. Its second function is prevention. Economic incentives to care can be generated through a variety of mechanisms. Those relied on by WCBs include experience rating and penalty assessments, related to either claims cost experience or observed hazards. As well, some systems make provision for compensation to workers removed from jobs as a prophylactic measure. Third, workers' compensation systems are engaged in the rehabilitation of injured workers.

Our primary focus is on the first two functions as they relate to reproductive hazards in the workplace. To the extent that we consider the third function, it is as "preventive rehabilitation" designed to compensate workers removed from hazardous exposures for the purpose of preventing the occurrence of reproductive harms. This, however, is discussed under the heading of prevention.

At the outset, we note that the present systems used by WCBs for coding injuries and diseases do not identify reproductive impairments as such. For example, Ontario has developed a data base for tracking occupational disease (Occupational Disease Information Surveillance System), but

it does not code the functional impairments caused by the disease. The National Work Injuries Statistics Program of Statistics Canada also does not capture the incidence of work-related reproductive impairment, although the coding system is under review. The absence of data not only impedes research but, because WCB data are relied on by policy makers, also interferes with the early identification of emerging problems and the development of appropriate responses. Inside the workers' compensation system, the absence of data about reproductive impairment results in underdevelopment of compensation policies and failure to trigger preventive mechanisms. The speculative nature of some of the following discussion about the compensation of reproductive harms and the preventive potential of the system is due to this lack of data and the effects of the lack on WCB policy.

Finally, we should note that despite the absence of hard data, it would be safe to assume that, except for Quebec, very few claims for work-related reproductive impairment enter the system. While it is impossible to accurately estimate the dimensions of work-related reproductive impairments, it is probably safe to assume that the number of actual claims seriously under-represents the true incidence of such work-related impairment.⁹¹

B. Compensation

We are concerned here with the compensation of work-induced reproductive injuries or impairments. These include reproductive impairment in adults and developmental impairment or death of the embryo, fetus, or child. Reproductive impairment can be caused by a wide range of chemical, physical, biological, and psychosocial hazards in the workplace and can take a variety of forms. While we discuss only incidentally the causes of reproductive impairment, we carefully examine the problem of proving causation. However, we first identify the principal reproductive impairments and injuries that might result in a claim for compensation. In this regard we include: sexual dysfunction, including impotence in men and desire and sensation disorders in women; infertility or miscarriage; therapeutic abortion medically recommended because of an exposure that would probably harm the fetus; stillbirth; and the birth of a child who is developmentally impaired, who is at increased risk of cancer, or whose own future children may be at increased risk.

To qualify for workers' compensation, a person must establish that: (1) he or she is covered by the Workers' Compensation Act; (2) the workplace is the cause of the harm suffered; and (3) the harm suffered is compensable. All of these issues can become problematic when seeking compensation for work-induced reproductive impairment. In the following sections, each of these criteria is examined in varying degrees of detail.

1. Coverage

Three issues arise with respect to coverage. The first relates to the general question of which industries are covered by workers' compensation legislation; the second to who is a worker under these statutes; and the third to whether members of the family of a worker who is covered can claim compensation if they are harmed as a result of the covered worker's exposure.

1.1 Which Industries Are Covered?

In general, workers' compensation legislation applies automatically and is compulsory for most employment. Agricultural and domestic workers, commonly excluded in the past, now are generally included. Compensation is compulsory for industries listed in a schedule under the act. Some industries, however, may not be listed and, therefore, are not automatically covered. These vary from province to province, as do the reasons for non-inclusion. Sometimes the rationale for not making coverage compulsory is that the work is considered low risk (e.g., banks, insurance companies, and other financial institutions in Ontario). Such judgments may be based on outdated assumptions about working conditions and their relation to health and typically adversely impact on female workers who are disproportionately employed in these "safe" industries. The trend, however, has been toward increasing coverage, and frequently, where coverage is not compulsory, there are provisions for opting in.

1.2 Who Is an Employee?

The second restriction is that compensation is payable only to employees. Thus, the threshold question of whether a person is an employee or an independent contractor must be answered in every case. The distinction is becoming even more important because of the growth in own-account self-employment, especially among women. WCBs have used a variety of tests to draw this distinction, often focussing on degree of control, ownership of tools, chance of profit, risk of loss, extent to which the person doing the work is outside the business organization of the employer, etc. Part-time and temporary workers are generally covered, but casual employees are excluded in some jurisdictions. Given the growth of "atypical" employment, the significance of this exclusion may be greater than in the past.

1.3 Family Members and Partners

The third and, for our purposes, most immediately significant restriction is that members of a worker's family or a partner who suffer harm as a result of the worker's exposure are not covered by the act. Thus, if a worker's partner suffered reproductive impairment through the absorption of a chemical from the worker's clothing, no compensation would be paid because the partner was not exposed as an employee. On the same basis, claims of children born with developmental impairments resulting from parental exposures at work will not be accepted by WCBs in Canada.⁹²

However, it is possible that some compensation might be paid to the exposed worker for the resulting harm to a family member or partner, but this is problematic because of the provision in most statutes that compensation is payable only for "personal" injuries.⁹³ We explore these in the discussion of compensable harms.

1.4 Non-Coverage and Tort Actions

Persons not covered by workers' compensation legislation are also not affected by its exclusive remedy provisions and can assert any common law claims that may be available. This option is considered in the section on tort liability.

2. Causation

Establishing the causal connection between work and reproductive injury is probably the single greatest obstacle faced by a worker seeking compensation. Except in the case of traumatic injury (e.g., a spinal cord injury resulting in impotence), the etiology of reproductive impairments is unlikely to be obvious. The reasons for this are clear, and the problem is not unique to the compensation of reproductive harm. The compensation of disease claims in general has presented serious difficulties for boards, and their record in resolving them has not been good. In the discussion below we discuss the reasons why establishing etiology is problematic and critically examine the way compensation boards have made decisions in the face of scientific and medical uncertainty.

The most obvious reason why it is difficult to establish causation is that we know very little about the causes of reproductive impairment. In particular, the effects of physical and psychological stress and chronic or acute exposure to chemical, physical, or biological agents in the workplace on the reproductive health of the worker are poorly understood and have not been extensively studied. This lack of information is widely noted.⁹⁴

A second and related problem is that reproductive impairments are not uniquely associated with workplace exposures. That is, many people may, for example, experience fertility problems. These may be caused by any number of factors, many of which will not be work-related. The etiology of the problem cannot be determined simply from its diagnosis.⁹⁵ Moreover, most physicians are trained to be more interested in diagnosis and treatment than in prevention. For this reason, they are unlikely to take an occupational history of the patient or to otherwise investigate whether a reproductive problem is work-related.⁹⁶ Unless workers discuss these problems among themselves, it is unlikely they will become aware of a possible work connection if it is not drawn to their attention by a health expert. This may go a long way toward explaining why so few claims for reproductive injuries or disease have reached the workers' compensation system.

2.1 General Principles

Once a claim is made, the crucial issues are how and on what basis determinations of eligibility are made in the face of uncertainty. To evaluate this process, we must first establish certain general principles regarding entitlement to workers' compensation.

In general, compensation must be paid "for personal injury by accident arising out of and in the course of employment." There is a rebuttable presumption in most acts that if an accident arose while the employee was engaged in work-related activity ("in the course of employment"), then it was caused by work ("arising out of employment"), and that if an accident arose out of employment, then it arose in the course of employment. Where the claim is for compensation arising from a traumatic accident, this presumption is important and useful. It does little, however, to assist in the adjudication of disease or other non-traumatic claims. Moreover, where the claim is for "disablement arising out of employment," it has been held, at least in Ontario, that the presumption does not apply. We return to specific provisions made for such claims after looking at some general principles.

2.1.1 Burden of Proof

In an adversarial system, the burden of proof lies on the party making the claim. Workers' compensation legislation in most provinces has relieved the worker, at least in theory, of the burden of proof. Instead, it has adopted an inquiry system that places a duty on the board to determine all questions arising under the act. The significance of this starting point is that while workers, employers, and physicians are under a duty to provide information available to them, the board is under a duty to make inquiries necessary to fill any gaps. Thus, if there is insufficient information in a file to determine a claim, the board should not conclude that the claim fails. Rather, the board should itself assume the burden of conducting further investigation to generate the required information.⁹⁷

The reality, however, is that the burden of proof does tend to fall on the worker, in the sense that if the information submitted to the board is insufficient to determine the claim, the board will likely deny it. Therefore, it is usually the worker who will have to provide the evidence of causation if it is not available from the other material obtained by the board. There is limited willingness by the board to conduct the kinds of inquiry necessary to the assembly or generation of the information necessary for determining whether a work exposure caused a reproductive harm. We return to the role of board staff and outside consultants later in this paper.

2.1.2 Standard of Proof

The standard of proof must also be considered. If the statute does not specify a particular standard of proof, then issues should be resolved on a balance of probabilities. In many jurisdictions, statutes have modified this position by giving workers the "benefit of doubt." That is, if the evidence is evenly balanced, then the board should adopt the conclusion favourable to

the worker. While this is straightforward in law, the reality is more complex.

Too often, it seems, a more rigorous scientific or medical standard of proof is substituted for the legal one. That is, a medical researcher will not conclude, for example, that chronic exposure to a particular substance causes sterility in human beings, unless the evidence approaches a standard near certainty. If the board allows a doctor to decide the general question of entitlement to compensation or relies on a medical opinion that the evidence does not establish causation, then it is in danger of applying the wrong standard of proof. Thus, it is essential for the board to keep the medical and legal issues separate.

A second problem is that boards may be likely to conclude that in the absence of evidence the standard of proof has not been satisfied. This is incorrect. The board should decide on the basis of the best available evidence.⁹⁸

A third problem is that a disease or disablement might be the result of a combination of factors and thus it might not be possible to determine which of the factors was the "dominant" cause. The concept itself is not very useful. The most common approach has been to adopt a significant contribution test, but it is often unclear what this means.⁹⁹ We return to this issue in the context of the compensation of disease claims.

2.2 Disease¹⁰⁰

Traditionally, the workers' compensation system has been cautious in its approach to disease claims precisely because of the difficulty of establishing work-relatedness. If the system began to compensate illnesses that were not clearly work-related, it was feared the system would be converted into a general sick-pay scheme. Thus, while in principle work-related disease claims were compensative, the criteria for establishing entitlement were often quite restrictive. Typically, only specified "industrial" diseases peculiar to or characteristic of certain occupations were compensable. Over time, however, many of these restrictions were loosened, but the problem of establishing causation still remains.

In the following sections, we examine the various routes to entitlement. Obviously, there are variations from province to province, and no attempt is made to identify all of them.

2.2.1 Industrial Disease

Historically, the first and only way to establish eligibility was through the industrial disease route. For example, in Ontario, the act makes the following provision:

Where a worker suffers from an industrial disease and is thereby impaired ... and the disease is due to the nature of any employment in which the worker was engaged, ... the worker is ... entitled to compensation as if the disease was a personal injury by accident.¹⁰¹

Thus, to obtain compensation, it must be established that the worker suffers impairment from an industrial disease and that the disease is due to employment. For our purposes, we assume the impairment can be established. This leaves the questions of whether the disease is an industrial disease and whether it was caused by work. Although these are distinct issues (for reasons that will become apparent), their answers are often closely related, and so we consider them together.

In the Ontario act, industrial disease is defined to include the following:

- (a) a disease resulting from exposure to a substance relating to a particular process, a trade or occupation in an industry,
- (b) a disease peculiar to or characteristic of a particular industrial process, trade or occupation,
- (c) a medical condition that in the opinion of the Board requires a worker to be removed either temporarily or permanently from exposure to a substance because the condition may be a precursor to an industrial disease, or
- (d) any of the diseases mentioned in Schedule 3 or 4.

With the exception of the medical removal provision, this definition reflects the restrictive attitudes toward the compensation of disease claims driven by the desire to ensure that non-eligible claims were not accepted. Moreover, as we shall see, these definitions create special difficulties in establishing claims for reproductive impairments. This can best be demonstrated by examining the different routes for claiming compensation for industrial disease.

(a) Scheduled Diseases

Disease schedules typically take the following form. In one column a disease is listed, and in a second column opposite the first a work process(es) is identified. The inclusion of a disease in the first column establishes conclusively that it is an industrial disease. If a worker with that disease was employed in the process listed opposite the disease, then either a rebuttable (in Ontario, Schedule 3) or an irrebuttable (in Ontario, Schedule 4) presumption arises that the disease was due to the nature of that employment. In some cases, no process is listed opposite the disease column. The effect of this is to establish that a worker with a scheduled disease has an industrial disease. However, no presumption arises as to its work-relatedness.

The use of such schedules reduces the difficulty of establishing eligibility. The problem is that most compensation boards long ago stopped adding diseases to the schedule. There are a number of reasons for this, including the view that schedules are too crude an instrument for establishing eligibility. Typically, they take no account of the duration or intensity of work exposure and do not allow the board to weigh that against non-work exposures. Because of these perceived defects, not only have

boards not added to the schedule, but they have also avoided giving effect to the presumptions it creates.¹⁰²

There are, however, a significant number of "diseases" on the schedule that might indeed cause reproductive impairment. It is clear they were not put on the schedule because of their harmful effects on reproduction, but, nevertheless, their presence may assist a claimant. For example, in Ontario, the scheduled diseases include "poisoning and its sequelae by" 15 different substances or compounds, some of which are known or suspected to cause reproductive impairment, including carbon disulphide, lead, and mercury.¹⁰³

However, there are difficulties in using the schedule. The principal one is diagnosis. To benefit from the schedule, it must first be established that reproductive impairment was caused by exposure to one of the listed substances. It is not enough to show that a worker was exposed to, say, lead in the workplace, because there is not a unique association between exposure to lead and a bad reproductive outcome. Any number of other factors could have caused this result. Moreover, workers cannot benefit from any presumption about work-relatedness until they can independently establish that lead poisoning caused their injury regardless of the source of exposure. In other words, the schedule does little to assist the claimant in proving causation, because the crucial issue may not be whether a workplace exposure caused the problem, but whether it was caused by a scheduled substance.

(b) Guidelines

As noted, boards have generally concluded that the scheduled disease route is not an appropriate mechanism for determining the merit of disease claims. A preferred instrument is guidelines. There are a number of differences between guidelines and scheduled diseases. First, scheduled diseases have typically been promulgated through legally binding regulations. Guidelines, however, are simply that — directives issued for the use of adjudicators. In practice, though, adjudicators treat them as if they were binding.

The structure and content of guidelines are also different. Typically, guidelines identify a disease and then specify a series of criteria. If met, the criteria give rise to a presumption that the disease was caused by work. They often include identification of processes in which exposure to particular substance(s) may have occurred and provisions regarding duration of exposure and inception periods, and they may also take into account non-work exposures (e.g., smoking). Claims that do not meet the criteria are considered individually on their own merits.

To date, no guidelines have been issued with respect to reproductive impairment. Nor, to our knowledge, is any attempt being made to develop guidelines in this regard. The desirability of using guidelines is controversial,¹⁰⁴ but, if carefully developed and properly implemented, they could improve decision making with respect to disease claims.

(c) Case-by-Case Adjudication

Case-by-case adjudication here refers to determinations of industrial disease claims not covered by a schedule or guideline or that do not meet their criteria for entitlement. In some cases, it is clear that a worker has an industrial disease. The difficulty in these cases is to establish that the disease was caused by work, and the general principles noted above apply. Establishing a claim for reproductive impairment is likely to be even more difficult, however, because it is unlikely to be obvious that the problem is caused by an industrial disease. Establishing that a disease is an industrial disease is a difficult task, especially when the endpoint, reproductive impairment (however defined), is common in the population at large. For this reason, WCBs and tribunals have been exceedingly wary of making this finding. In at least some jurisdictions, however, they have developed another route to the compensation of diseases, eliminating the need to establish that the disease fits the definition of industrial disease. This is considered below.

2.2.2 Disablement

Although statutes often define eligibility by reference to personal injury by accident, the use of the term *accident* is misleading. In Ontario, for example, accident is defined to include "disablement arising out of and in the course of employment."¹⁰⁵ Other jurisdictions have achieved similar results, either by repeal or by definition. The significance of this for our purposes is that any disabling disease is compensable, even if it is not an industrial disease as defined in the statute. To be eligible, all that needs to be established is that the worker has a disabling disease caused by work.

This route to compensation has become a favourite one in Ontario because it permits the board to decide cases on an individual basis, without coming to conclusions about matters perceived to require an expertise that may be beyond its competence. For example, in *Decision 850*, the Workers' Compensation Appeal Tribunal (WCAT) panel noted,

In our view, it is a matter of significant complexity to decide whether a disease is peculiar to a particular process, trade or occupation. The extent of the complexity was explicitly recognized by the Legislature when, in 1985, it established the Industrial Disease Standards Panel.¹⁰⁶

Thus, the tribunal is extremely reluctant to find that a particular medical condition is an industrial disease.¹⁰⁷

When determining whether a disease claim is eligible through the disablement route, there are no applicable presumptions to assist the worker. Moreover, previous decisions are of limited use because it is necessary to show in each case there was a workplace exposure that made a significant contribution to the occurrence of the injury. Given the lack of knowledge about human reproduction generally and the sparsity of information about the effects of exposure to chemical, physical, biological, and psychosocial

hazards on reproductive systems, establishing causation is likely to be a difficult task in many situations.

It is interesting that in none of the handful of reproductive impairment cases decided by WCBs that have come to our attention was the issue of causation in dispute.

2.3 Stress

Claims for reproductive impairment based on workplace stress present special difficulties because of the way in which stress claims are generally handled. As there are no special provisions in the statutes regarding stress, such claims are handled either as disease or as disablement claims. The disablement route is the most common.

Stress claims are typically divided into three categories: physical-mental; mental-physical; and mental-mental.¹⁰⁸ Reproductive impairment claims could fall into any of these categories, and so a brief discussion of each is warranted.

2.3.1 Physical-Mental

A worker suffers a disabling back injury leaving her or him severely depressed. One of the manifestations of depression is diminished libido. Most systems recognize the causal connection and will compensate the psychological repercussions of a physical work accident, although there may be disputes over the cause and extent of the psychological disability for this particular worker and the size of the appropriate award. With respect to reproductive impairment, the only special issue is the appropriate award. Should additional compensation be paid because the psychological consequences of the physical accident involve a reproductive impairment? We return to this issue in the section on what is compensated.

2.3.2 Mental-Physical

A worker is under great stress at work and suffers a stroke. Sexual function is physically impaired, resulting in reproductive impairment. Most jurisdictions will recognize that the stroke is compensable in principle, although there may be difficulties in proving causation. As in the physical-mental situation, the special problem that arises is whether an additional award should be made because of the reproductive impairment.

2.3.3 Mental-Mental

These claims are usually subdivided into two categories: acute and chronic. The first (e.g., bank teller witnesses robbery in which co-worker is shot) is generally compensable without any special restrictions on eligibility. The second is more problematic and has been accepted on a limited basis at best. The situation varies from province to province.¹⁰⁹ In British Columbia all chronic stress claims have been rejected, while in Ontario it is necessary to show either that stress at work was greater than average or, if workplace stress was not unusual, that there is "clear and convincing evidence that the ordinary and usual work-related pressures [in

fact] predominate in producing the injury."¹¹⁰ Thus, a worker who wanted to claim compensation for a reproductive impairment resulting from depression caused by stress at work not only would face the same difficulty as noted above, but potentially would have to overcome a particularly restrictive approach to causation. This approach has been adopted because it is exceedingly difficult to measure stress and to distinguish between work and non-work stress factors. Boards are worried that a more open test would change the system into one of general sickness and disability compensation.

3. What Benefits Are Available?

Once it has been established that a worker is covered by the act and has suffered a disablement, condition, or loss resulting from work, it must then be determined whether compensation is payable for the kind of loss suffered. Workers' compensation typically provides three kinds of benefits: medical aid; money; and rehabilitation services. Because there are a variety of reproductive injuries and losses — only some of which are disabling, and because workers' compensation systems vary — determining what benefits are available is not a simple task. However, we can indicate a few basic principles.

In all systems, workers are compensated for income losses resulting from work-related disabilities. There is a maximum to the gross rate of earnings used in the calculation of wage-loss benefits, and compensation is fixed as a percentage of that gross rate. The percentage varies between 75 and 90. The costs of treating and rehabilitating the worker are also covered. Punitive and exemplary damages for egregious misconduct on the part of the employer are not awarded within the workers' compensation system. Compensation for pain and suffering is more problematic, and no general principle can be quickly stated.

In the following sections, we will consider medical aid and monetary benefits and their availability in relation to reproductive injuries. Rehabilitation is not considered except as a component of medical aid since it otherwise has no special significance in relation to reproductive injury.

3.1 Medical Aid

As a general matter, workers are entitled to compensation for any medical aid that may be the necessary result of an injury. This entitlement does not depend on a worker becoming disabled. Thus, it is available independent of eligibility for monetary benefits. This is particularly important in reproductive injuries, which, in many cases, will not disable the worker from work.

The difficult question arising in this context, aside from the general problem of proving causation discussed above, is the extent of medical aid available. In this regard, workers are generally covered under provincial health insurance plans. From the worker's point of view, therefore, it makes no difference whether the costs of medical care are charged to the health insurance plan or to the WCB unless coverage is more comprehen-

sive under the latter scheme. This is the question we must examine, particularly as it relates to the treatment of reproductive impairment.

WCBs generally provide the costs of drugs, while provincial health care plans often do not. This is one clear difference in the scopes of their respective coverage. However, when we discuss particular reproductive impairments and their treatment, we enter into an area that becomes more speculative if only because few claims have been made.

If a worker became infertile because of a work-related injury or disease, would the costs of fertility treatment be borne by workers' compensation? This might be significant, because not all the costs of fertility treatment will necessarily be covered by provincial health care plans. In particular, if *in vitro* fertilization is being sought, only the Ontario health insurance plan currently covers its costs, and this is under review.

To date, only Alberta reports having dealt with a claim for fertility treatments. It arose out of an accident that resulted in quadriplegia in a male worker. In that case, the board paid for the cost of artificial insemination, drug therapies, fertility clinics, and transportation costs for both the worker and his spouse. Administrators from other boards (which have not had claims for fertility treatment) speculated on their likely disposition and offered a range of views. On the one hand, in Manitoba it was thought unlikely that fertility treatments would be allowed because they would not be considered treatments required "to cure and relieve from the effects of the injury." On the other hand, British Columbia and Ontario expressed the view that in principle compensation for such treatments would be payable, but that each case would have to be considered on its own merits and justice.

Where workplace exposure to a hazardous condition results in pregnancy complications, miscarriage, or a decision to terminate a pregnancy prematurely, the medical costs of required treatment or procedures would likely be covered by workers' compensation.¹¹¹

In addition to physical treatments, a worker suffering reproductive impairment might seek counselling. In principle, this should be covered by workers' compensation provided the counselling is required to treat the injury or its sequelae. More problematic is the kind of treatment that might be covered. In most provinces, psychiatric services are covered by health insurance plans, but counselling services provided by others are not. Often psychiatric treatment would not be appropriate, and the question of whether workers' compensation would assume the cost of counselling by non-medical personnel would become particularly important to the affected worker. As a general matter, workers have the right to select their doctor or *other practitioner*. This would seem to imply a right to select a non-medical counsellor, but many boards have adopted more restrictive practices. For example, in Ontario the board will deny medical aid to cover the cost of non-medical counsellors at first instance but may allow it on appeal,

if convinced that such treatment is required as a result of the injury and is appropriate.

Overall, the level and type of medical aid to which a worker is entitled are not fixed in law. Board decisions may be driven by a variety of factors, including economic and political ones. If and when treatment of reproductive impairment arises, boards will have to face these difficult issues and will need guidance in doing so.

3.2 Monetary Benefits

Monetary benefits are usually classified as temporary total, temporary partial, permanent total, or permanent partial. Reproductive injuries are unlikely to result in total permanent disability, although a person who is totally disabled is also likely to be reproductively impaired. For our purposes, we distinguish primarily between benefits for temporary and permanent disability. Where benefits are based on wage loss, we do not consider the method of calculation.

3.2.1 Temporary Disabilities

A worker who is absent from work because of a compensable disability is generally entitled to temporary total disability (TTD) payments, often known as "wage-loss benefits." The temporary partial disability (TPD) classification is infrequently used. It typically involves a situation in which a worker has recovered sufficiently to return to modified duties and is expected to recover to the extent of being able to return to his or her former job. We focus on TTD benefits in relation to reproductive injury.

In most cases, reproductive injuries are not disabling in the sense that they cause workers to be absent from work. However, there are cases where TTD can result. For example, a reproductive injury caused by a traumatic blow to the abdominal or genital region may be disabling. Similarly, a female worker who miscarried or terminated her pregnancy prematurely because of a work hazard might also be temporarily totally disabled for either physical or psychological reasons. Clearly, a worker in this situation would be entitled to wage-loss benefits.

Workers who are not totally disabled may still be able to collect total disability benefits where, for example, they are absent from work in order to receive treatment for a compensable disability. Thus, for example, a worker who was being treated for infertility arising out of employment would be eligible not only for medical aid but also for wage-loss benefits in the event he or she was required to be off work for that purpose.

Finally, there is no compensation for pain and suffering allowed within the framework of TTD benefits. A man who suffers an excruciating injury to his genital region but fully recovers is compensated only for wage loss. Similarly, a woman who miscarries is not compensated for any emotional pain she may have experienced, except to the extent that it was disabling and resulted in wage loss.

3.2.2 Permanent Disabilities

There is much greater diversity among jurisdictions in the compensation of permanent disabilities. These differences are particularly significant with respect to the compensation of permanent reproductive impairment. For simplicity's sake, we discuss two models of compensation rather than enter into a detailed consideration of particular jurisdictions. In the first, periodic payments are calculated according to the physical impairment system, and there are no lump sum payments to compensate for other losses not covered by the periodic payments. In the second, periodic payments are calculated in relation to actual wage loss, but, typically, a lump sum payment for other losses is also paid.¹¹²

3.2.2.1 Physical Impairment Systems

In most provinces, including Alberta, British Columbia, Manitoba, and Ontario, for injuries prior to 1 January 1990, workers who reach less-than-total maximum achievable recovery are entitled to compensation for permanent disability based on the degree of physical impairment. In legal theory, when relying on physical impairment, the board is calculating the impairment of earning capacity based on the nature and degree of injury. To facilitate the calculation of pension awards, boards commonly adopt disability rating schedules. Where disabilities are rated, the scheduled benefits are awarded even though the actual impairment of earning capacity may not be affected. Indeed, in British Columbia, it was held that evidence of the impact on actual earnings was irrelevant.¹¹³ Where, however, the actual loss of earnings is greater than the degree of physical impairment, many provinces provide wage-loss supplements.

The use of the physical impairment system for calculating loss of earning capacity may result in awards that *de facto* compensate for non-economic loss even though *de jure* (by law) the board has no authority to do so, except perhaps in cases of facial disfigurement.

Where disabilities are not rated, boards must determine whether and at what level a permanent disability pension should be awarded. It is in cases of this sort that the board must often consider the underlying basis for permanent partial disability (PPD) benefits. Claims for reproductive injury often fall into this category because they are relatively recent and because there is often no direct or obvious permanent impairment of earning capacity.

(a) Male Impotence

Claims by men for impotence are a good example of the problem boards face. The first reported case in Canada was decided in 1975 in British Columbia while the board was chaired by Professor Ison.¹¹⁴ There, the board rejected the argument that impotence was not compensable without proof of actual loss of earning capacity. Rather, the board recognized that impotence may have indirect effects on earning capacity:

It could result in feelings of inadequacy or depression, or otherwise result in a loss of self-confidence or in introversion. If any of these

consequences appear, the worker might be perceived by his employer as not portraying leadership qualities, and therefore as not being an attractive candidate for promotion. If the time comes when it is necessary for him to apply for a new job, he may not appear to potential employers as congenial as other applicants.¹¹⁵

Moreover, once the possibility of an indirect effect was accepted, the board held that the injury should be compensated in the same way that injuries to other organs were under the Permanent Disability Evaluation Schedule. That is, there was no requirement to prove actual loss of earnings capacity. In calculating the degree of physical impairment, the board age-adjusted the award on the basis that younger men were more likely to be adversely affected than older men.

A few years later, the Ontario board developed a permanent disability rating schedule for impotence and sterility.¹¹⁶ It provided for a 10 percent disability rating where male impotence resulted from either direct trauma to the penis or the loss or partial loss of the penis. Secondary psychological disabilities arising from impotence were also compensable.

The issue of compensation for impotence was more recently considered by the WCAT. It arose out of a case in which a worker's impotence was attributable to nerve damage resulting from back surgery to correct a compensable back injury. The panel of WCAT hearing the case considered the B.C. decision and the board policy of compensating impotence but rejected the views expressed. Instead, it held that "the link between impotence and an indirect impact on earning capacity is too tenuous and speculative" to justify awarding a pension in the absence of evidence that the condition was disabling.¹¹⁷

A subsequent panel decided to allow a re-hearing on the issue of entitlement to compensation because the parties had not addressed this issue at the original hearing.¹¹⁸ On reconsideration, the panel decided to allow the claim. The panel adopted the principle that "the pension is intended to represent the impairment of earnings which would be caused to the average unskilled worker in Ontario by an injury"¹¹⁹ and that individual circumstances were only to be examined with respect to supplements. The panel heard testimony from a psychiatrist who testified that male impotence often results in severe psychological problems that may have a negative impact on work and on this basis determined that the average unskilled worker would suffer an indirect psychological impairment of earning capacity of 10 percent.

Other provinces that use physical impairment also compensate male sexual impotence. For example, in Alberta impotence is compensable but only where its cause is organic.¹²⁰ The Permanent Disability Rating Schedule rates impotence at a 15 percent loss, but disability awards for the 12 impotence cases coded as such ranged between 5 and 40 percent.

These cases indicate some of the possibilities and limitations facing other claims for permanent reproductive impairment. In particular, it is clear that before permanent disability awards for an injury are generally

available, the board must accept that the injury will at least indirectly impair the earnings capacity of the average worker. In the case of male impotence, the board used the average male worker as the standard. Presumably, if women claim reproductive injuries, the standard would be the average female worker. If the board does not accept that the average worker would be adversely affected, it would still be possible to argue that the particular individual did suffer an impairment of earning capacity and that a pension should be awarded on that basis. In such a case, however, proof of actual earning impairment would likely be required.

It is also clear in the male impotence cases that the dominant factor leading the board to award compensation was not the loss of reproductive function, but the loss of sexual function. Thus, these cases provide only limited insight into how a board might resolve claims for impairment of reproductive function that do not involve loss of sexual function.

(b) Female Sexual Dysfunction

There is no female equivalent to male impotence, although women may suffer from a variety of sexual dysfunctions, including desire and sensory disorders. Perhaps for this reason, boards have been careful not to extend their decisions on the compensation of male impotence to female sexual dysfunction. For example, in the B.C. decision, the board stated specifically that the decision relates only to male workers and that in the event a woman brought such a claim, "the Board must then consider to what extent similar or different principles should be applied, and whether the same or different percentages should be used."¹²¹ In Ontario, the board's rating schedule indicates that a woman's claim for "impotence" would have to be decided on an individual basis and no preset percentage award is indicated.¹²² The WCAT decision was not restricted to men, but its applicability to women is doubtful in light of the gender-specific condition and evidence of psychological reaction before the tribunal.

The connection between sexual dysfunction and reproductive impairment is closer in men than in women. An impotent man cannot engage in sexual intercourse (at least without mechanical assistance), while a woman with a desire or sensory disorder can, although she may be less inclined to do so. Therefore, calculation of PPD benefits would likely take account of loss of sexual function only. Presumably, eligibility and amount would depend on the ability to establish that the average working woman's psychological reaction to sexual dysfunction would likely adversely affect her earning capacity. Given the pervasiveness of sexual stereotyping, both by employers and by boards, it is likely that women will have more difficulty establishing entitlement than men. If reproductive impairment could be established, the loss probably would be handled as an infertility claim (see below).

(c) Sterility or Infertility

As noted above, impotence has been compensated on the basis of the impact of loss of sexual function on male earning capacity. Cases where the dominant or exclusive loss is of reproductive capacity require separate consideration. Although the principle upon which sexual and reproductive impairment is compensated should be the same (effect on earning capacity), boards have adopted a range of policies, often without any explicit discussion of the basis for compensation.

On the one hand, in Ontario a 10 percent permanent disability pension is awarded to a man who has become sterile either because of physical injury to his genitals (loss of penis and/or partial loss of penis and/or loss of both testes, but only 2 percent for loss of one testicle) or because of non-traumatic causes, including radiation and toxic chemicals. Female sterility is considered on an individual basis. Moreover, there may be separate entitlement for psychological disability secondary to either sterility or impotence.¹²³ This last provision is odd in that it suggests that it was not the psychological impact on earning capacity that justified the pension award in the first place. This would contradict the stated rationales for compensating impotence and may support the earlier suggestion that sometimes non-economic losses may be compensated surreptitiously in systems that do not expressly provide for it. Manitoba provides a 5 percent disability award for sterility when not accompanied by loss of gonads.

British Columbia, on the other hand, takes the view that sterility as such is not compensable either in men or in women. In an unreported decision arising out of a compensation claim for sterility resulting from a tubal ligation recommended to treat a work-related blood condition, the director of appeals administration upheld a determination by the commissioners "that sterility is not likely to have any direct effect on earning capacity and that such indirect effects that it may have are speculative and remote." However, the question of the board's responsibility for the treatment and compensation of post-traumatic stress syndrome was left to the claims adjudicator to consider.

Thus, the decision kept open the possibility that the psychological sequelae to sterility caused by work might be found to impair earning capacity and to be compensable on that basis. This decision has been brought to the British Columbia Council of Human Rights and is currently before a member designate for adjudication. Finally, it is noted that the board has indicated that its policy is under review.

In Alberta, the Permanent Disability Rating Schedule rates infertility at 5 percent, but the policy manual indicates that age should be taken into account in determining the percentage.¹²⁴

In sum, in theory sterility will be compensated only if the board accepts that it has an effect on the earning capacity of the average male or female worker. In practice, the decision to compensate may be based on

other considerations that cannot be openly relied on because they lack legal foundation within the system for determining entitlement to PPD benefits.

(d) **Miscarriage and Abortion**

A permanent disability claim for miscarriage or abortion because of employment would be considered only if there was a resulting permanent physical or psychological disability that was either scheduled or found to impair earning capacity. No award would be made for the loss of the fetus itself.¹²⁵

(e) **Birth Defects**

As noted in regard to coverage, children of workers are not eligible to claim compensation for harm they have suffered as a result of parental exposure. Here we consider whether the parent could claim compensation. Boards in Canada have not experienced such a claim, and most declined to speculate on its resolution. It would be difficult to argue eligibility on the basis that attending to the special needs of the child is an injury to the worker that has impaired her or his earning capacity. It might be argued, however, that the injury occurred to the fetus when it was a part of the mother, and that the mother could claim compensation on this basis. It is unlikely such an argument would succeed. It is possible that a worker in this situation might develop compensable psychological problems, but these are likely to be of a temporary nature.

3.2.2.2 Dual-Award Wage-Loss System

In some jurisdictions, including Ontario after 1 January 1990, Quebec, and Saskatchewan, permanent disabilities are compensated through the payment of two awards. The first is for actual wage loss. The loss of earnings is calculated by reference to the wage rate on the claim, less what the worker is earning or deemed to be capable of earning, and what the worker is prevented from earning for reasons other than the compensable disability. There is no attempt to calculate the average loss of earning capacity based on physical impairment; a worker who is earning more than the wage rate on the claim is not eligible for an actual wage-loss payment even if there is significant disability. In regard to claims for reproductive impairment, it is clear that to be eligible for this award economic loss must be found to have resulted in fact.

Permanent physical or psychological impairment is compensated, whether or not there is economic loss, through a separate lump sum payment. This represents a form of compensation for non-economic loss. The calculation of the award varies, but typically it is done by awarding a percentage of an age-adjusted base amount. In Ontario, for example, the base amount is \$45 000, plus or minus \$1 000 for each year below or above the age of 45 at the time of the accident, with a maximum \$20 000 variation. The percentage is calculated according to the physical impairment method using disability rating tables. If a particular impairment is

not listed in the table, the disability percentage will be calculated by analogy.

Quebec has adopted a regulation establishing percentage impairments.¹²⁶ It deals with a number of conditions likely to involve impairment of reproductive function, although it is not always clear to what extent the percentage reflects that loss. For example, the regulation rates the anatomical or functional loss of both ovaries at 21 percent, but then provides for an additional 7 percent for women 50 years of age and younger and 2 percent for women 51 years of age or older. Presumably the difference is related to the likelihood that the woman is menopausal. The higher percentage, however, may not be based on the loss of reproductive capacity that premenopausal women suffer, but on other physical consequences of early menopause (e.g., increased risk for coronary heart disease, osteoporosis, etc.). Loss of the uterus is rated at 10 percent. In contrast to the rating for internal genital organs, damage to external genital organs is explicitly rated according to impairment of both sexual and reproductive function (interference with delivery by birth canal). Up to 30 additional percentage points are awarded for suffering and loss of enjoyment of life (SSEL) where problems of sexual function result from damage to the internal or external genital organs. No separate SSEL award is made for loss of reproductive function, and it is not clear that this loss has already been taken into account in fixing the base percentages, except in cases where it is explicitly noted. Permanent psychological problems caused by reproductive loss may be compensated separately.

There is similar ambiguity about the basis for rating permanent damage to the male genital system. Complete bilateral anatomical or functional loss of the scrotal contents is rated in the same way as the loss of ovaries in women, including the larger increment for men 50 years of age or younger than for those 51 years of age and older. Men's loss of sexual function is also compensated in the same way as women's.

Ontario has adopted the American Medical Association Guides to the Evaluation of Permanent Impairment for determining percentages. The guide is explicit in taking impairment of reproductive function into account in calculating percentage amounts. The value of impairment of the reproductive organs of men is calculated for the 40- to 65-year-old age group with recommendations that the values be increased by 50 percent for younger men and decreased by 50 percent for older men. The base value for total anatomical or functional loss of scrotal contents is 15 to 20 percent. For women, values also vary according to whether the woman is in her childbearing years, and full loss of the ovaries in a premenopausal woman is rated between 30 and 35 percent.¹²⁷ Because of the differences in systems, the dollar amount of the award varies. In Ontario, for example, a 25-year-old woman who suffered the full loss of her ovaries would be awarded a lump sum payment of \$21 000 (45 000 base + 20 000 age

increment \times 35 percent). Permanent psychological disabilities resulting from reproductive loss may result in additional payment.

In none of these systems is any provision made for lump sum payments for miscarriage itself; nor is there any provision for compensation to the worker whose child is born with developmental disabilities.

C. Prevention

The workers' compensation system may play a role with respect to the prevention of harm in three ways. First, it can, through its funding mechanisms, create economic incentives to care. Second, the compensation system may become involved in educating and advising employers and workers about the risks in their workplace and how to eliminate or reduce them. Third, it can make provision for workers to receive compensation when they are removed from a hazardous situation to prevent or minimize the chance of harm occurring.

1. Economic Incentives to Care

Workers' compensation is funded through employer contributions. It is illegal for the employer to place a levy on employee earnings or to otherwise make the employee contribute directly to the cost. Of course, the actual cost of coverage may be shifted to employees through lower wages or to consumers through higher prices. Nevertheless, the use of economic incentives to care is premised on the assumption that employer behaviour can be modified through changes to the levies and charges made by the WCB.¹²⁸

Typically, employers are divided into rate groups based on their classification. In effect, each rate group forms its own mutual insurance fund, and the assessments paid by the employers in that group are expected to meet its compensation costs. Industries are classified according to their end product or service. There is an assumption that the risks within a group will be similar and so a common assessment is equitable. A classification system, however, creates no economic incentives for employers to reduce their claims experience because no employer within a group can fully capture the benefits of reduced compensation costs. Rather, the benefit is spread among all employers in the class, including those who have not invested in safety.¹²⁹ In public choice theory, this is called a free-rider problem. For that reason, compensation boards seeking to create economic incentives to care have resorted to other mechanisms to achieve their goal. These are reviewed below.

1.1 Experience Rating

Experience-rating schemes allow the board to vary an employer's rate of assessment above or below the standard group rate depending on the *claims cost experience* of the employer. In theory, by rewarding those with lower-than-average compensation costs and charging more to those with

higher-than-average compensation costs, appropriate economic incentives are created to reduce claims cost by investing in risk reduction.

Despite the increasing reliance on experience rating by compensation boards,¹³⁰ there are numerous grounds for doubting its efficacy and fairness. These are discussed thoroughly by Ison.¹³¹ Here we focus on some of the concerns that are particularly cogent with regard to reproductive hazards. First, claims for reproductive hazards must enter the system before they influence claims cost experience. This has not yet happened, so any discussion of experience rating as a specific response for preventing work-induced reproductive disorders is premature.

Second, claims cost experience can be reduced in a variety of ways, only one of which involves reducing risk. Better monitoring of claims by the employer might be a more cost-effective way of reducing claims experience. More particularly, if the employer believes that a particular group of workers is more likely to make claims for reproductive injuries than others, then reducing the presence of that group in the workplace may be the preferred method for reducing claims cost experience. So, for example, if it were decided that the only way to protect reproductive health in some situations is to remove pregnant women, and the costs of protective removal were charged to the employer's claims cost, then an experience rating scheme might discourage the employment of fertile women. Moreover, even if such a practice were prohibited under human rights legislation, the likelihood of detection and the possible sanctions would likely be too low to constitute a deterrent to a profit-maximizing employer.

Finally, it should be noted that empirical studies of experience rating in workers' compensation systems have not detected any influence on employer safety performance.¹³²

1.2 Penalty Assessments — Based on Claims Cost

In some jurisdictions, boards have the legal authority to impose penalty assessments on employers whose claims cost experience is significantly worse than the average in their rate group. These assessments can be levied even in the absence of an experience rating plan. In Ontario, the board automatically increased the assessment by 100 percent if certain criteria were met. If claims cost did not improve in future years, the penalty assessment would be increased further. Employers could appeal such assessments; where a satisfactory explanation was offered or the employer indicated a willingness to devote more effort and resources to safety improvement, the assessment would be lowered.¹³³

Many of the same concerns relating to experience rating apply equally to penalty assessments based on claims experience. Unless compensation for reproductive harm has a significant impact on claims experience, penalty assessments will not influence employer behaviour; if they do have a significant impact, then discriminatory strategies for reducing claims cost may be resorted to by employers.

1.3 Penalty Assessments — Based on Observed Hazards

In some jurisdictions, boards have the legal authority to impose penalty assessments on the basis of observed hazards. Assessments are imposed only where conditions are detected that are unusually hazardous or involve a serious violation of health and safety laws. British Columbia has been a leader in the use of this approach and it has been favourably reviewed.¹³⁴ Its overall strengths and weaknesses are considered in the proposals section where we discuss how to punish. In that regard, penalty assessments are compared to prosecutions under health and safety legislation or under the Criminal Code. For now, we note that penalty assessments of this sort are flexible instruments. Because the economic incentive takes the form of an insurance premium and not a fine, there is no need to have regulations establishing specific standards, nor to prove before a court, or even an administrative tribunal, that a violation of a law has occurred, before a penalty assessment can be imposed.

With respect to the use of this approach as a means of preventing reproductive harm, its most obvious benefit is that action can be taken before harm occurs and its costs reflected in employers' claims experience. As soon as it is determined that certain conditions are or might be hazardous to human reproduction, employers can be put on notice that they must eliminate the hazard and that failure to do so will result in a penalty assessment. Moreover, if the option of removing particular workers rather than the hazard is not permitted, then an employer will not be able to avoid the penalty through discriminatory hiring practices. Thus, two of the most significant drawbacks to experience rating and penalty assessments based on claims cost experience can be avoided.

1.4 Penalty Assessments — Based on Safety Audits

This is a mechanism similar to the previous one and has been adopted by some provinces, including Ontario, where it is known as the "Workwell Program." In such a program, employers are selected for safety audits on the basis of a variety of factors, which may include claims cost and frequency, information from occupational health and safety officials, complaints by workers, etc. Board officials conduct the audit, which may include an examination of both conditions in the workplace and employer health and safety policies and programs. Employers whose health and safety performance is found to be substandard are given time to rectify the situation prior to the imposition of penalty assessments. When penalty assessments are levied, the amount depends on the extent of non-compliance with audit criteria. The program can also be used to reward employers whose safety performance is outstanding.

This can also be an effective method for protecting workers from reproductive hazards. As was the case with penalty assessments based on observed hazards, we do not need to wait until harm has occurred, the harm has been reported to the board, and the claim has been accepted by the board. It is truly proactive. Moreover, it would be relatively easy to

adapt this program to the regulation of reproductive hazards by making protection from reproductive harm an evaluation criterion in the audit. Employers could be required to remove identified hazards; offer education and training programs; and conduct or obtain assessments of the likely reproductive effects of particular chemical, biological, or physical agents and changes in work practices prior to their introduction into the workplace. Unacceptable exclusion strategies could also be monitored through such an audit. Moreover, as in the case of penalty assessments based on observed hazards, these measures can be implemented without first having to establish that laws have been broken.

Finally, it should be noted that in Ontario the Workwell Program does not make any special provision for reproductive hazards. To the extent they are taken into account, it is through a general assessment of employers' existing approaches to health and safety, including the way employers document actions taken with respect to audits and assessments conducted for chemical, physical, and biological agents.

2. Education

WCBs have often conducted their own publicity campaigns, funded employer safety associations, and, on occasion, funded worker training programs. The effectiveness of employer safety associations in particular has been questioned;¹³⁵ in Ontario they have been placed under the authority of a newly created Workplace Health and Safety Agency (WHSAs), which has a mandate to develop, deliver, or fund health and safety education. The WHSA is funded directly by the WCB.¹³⁶ It is developing criteria for the certification of health and safety representatives, but it is not developing programs relating to reproductive hazards and their prevention at this time.

3. Protective Reassignment/Removal

Other than Quebec, no province directly gives employees a general statutory right to protective reassignment (or compensation when an appropriate reassignment is not available) when exposure to a contaminant has resulted in a condition that may be a precursor to a disabling condition or disease; nor do they make special provision for pregnant and breast-feeding workers. Rather, where such rights exist, they arise with respect to specific conditions or as incidental outcomes of other provisions. We first examine the situation outside Quebec and then consider the scheme adopted there.

3.1 Outside Quebec

As a general matter, compensation is payable only when the worker is disabled. A worker who is removed from work as a precaution against future disability generally cannot collect compensation. There are, however, exceptions.

In Ontario, an industrial disease is defined to include a "medical condition that in the opinion of the board requires a worker to be removed either temporarily or permanently from exposure to a substance because

the condition may be a precursor to an industrial disease."¹³⁷ This sub-clause was enacted to give statutory authority to policies the board had already adopted with regard to miners at Elliot Lake who had been exposed to high levels of silica and to asbestos workers at the Scarborough plant of Johns-Manville.¹³⁸ In addition, under this provision uranium workers who reach the maximum exposure level may be entitled to compensation.¹³⁹ Similarly, workers with occupational exposures to lead or mercury are eligible for compensation when action levels established in codes for medical surveillance attached to the regulations are exceeded.¹⁴⁰

The last two categories are obviously significant for the protection of reproductive health given the known hazards resulting from exposure to radiation and lead. However, the action levels for removal may not be sufficiently low to provide the desired level of protection. We return to this question in the standards section. Another problem with the subclause is that it is narrowly drawn. The condition must be a precursor to "an industrial disease." Given the rather restrictive approach the board has followed in recognizing new industrial diseases, it may be difficult to meet this requirement. In addition, establishing that a worker is reaching the point at which further exposure may temporarily or permanently impair her or his reproductive capacity will be difficult because of the lack of solid information about the reproductive effects of exposure to many substances.

Some provinces that do not have a specific protective removal provision in their statutes nevertheless award compensation and rehabilitative services to workers suffering from a non-disabling workplace condition. For example, Manitoba takes the position that a worker who is required to be removed from continued exposure to prevent disablement has suffered a personal injury by accident arising out of and in the course of employment. However, before compensation is awarded, there must be a finding that there is a significantly enhanced risk for increased disability or impairment if exposure continues. Possible risks would not be sufficient to trigger compensation for preventive removal.¹⁴¹

Other provinces have adopted a more restrictive approach. For example, in British Columbia the board expressed the view that it is unlikely a pregnant worker who is required to be removed from the workplace to avoid an exposure that may be harmful to her or to her fetus would be eligible for compensation. This approach is based on an earlier decision that would have denied compensation to a worker exposed to lead who took time off work to prevent lead poisoning. In the board's view, compensation was payable after the event, not to prevent injury from occurring.¹⁴² On the other hand, an employee who had been found to be suffering from an industrial disease and whose condition would worsen if he returned to his old job was held to be disabled.¹⁴³

Overall, it seems that even in provinces that compensate for protective removal, the criteria are narrowly drawn. The reasons for this are obvious. Boards are concerned that all workers exposed to hazards at work could argue that by continuing their exposure they are at risk of being injured;

that removal from the hazard would prevent injury; and that they should be compensated for their resulting wage loss. To avoid opening the flood-gates, compensation for preventive removal, if it is to be given at all, must be given only where the circumstances are exceptional. Because pregnant women and fetuses are seen to be at special risk, they have often met this criterion. Protective removal to prevent other reproductive harms may be permitted where there are already signs of deterioration, but few, if any, claims of this sort have been made.

3.2 Quebec

Unlike other Canadian jurisdictions that have either narrowly drafted provisions for compensation during protective removal or, more frequently, none at all, Quebec health and safety laws contain two provisions extending a broader and better defined right to protective reassignment and compensation for wage loss resulting from a work stoppage where no reassignment is made. Where compensation is paid, the employer pays the employee directly at her or his regular pay for the first five days, and thereafter the employee receives payments from the workers' compensation system. These substantive rights are contained in health and safety legislation and exist in addition to the general right to refuse unsafe work (see below).¹⁴⁴

3.2.1 The General Right to Protective Reassignment/Compensation

The Occupational Health and Safety Act (OHSA) makes protective reassignment or removal with compensation available to any worker who furnishes a medical certificate attesting that exposure to a contaminant entails a danger to the worker that is evidenced by signs of deterioration in the worker's health. Although the legislation authorizes the CSST to make regulations that identify contaminants in relation to which a worker may exercise the right of reassignment and that determine the criteria on which a deterioration in health would warrant reassignment, no such regulations have been adopted. As a result, this section of the act is inoperative. Therefore, it cannot be determined whether this provision would afford workers in Quebec a greater opportunity to obtain protective reassessments or compensation for removal than is enjoyed by their counterparts in other provinces where preventive compensation is paid under workers' compensation acts.

Although no other province provides a direct statutory right to protective reassignment, some provincial WCBs compensate workers who are required to be away from work because they have developed a condition that is a precursor to an industrial disease or some other disablement. This right could provide workers with some of the benefits of a right to protective reassignment, but this depends on whether conditions that could adversely affect reproduction outcomes are included. To be effective, the right to compensation for precursor conditions must also be well publicized.

3.2.2 Pregnant and Breast-Feeding Workers

The second provision in Quebec's health and safety laws gives pregnant and breast-feeding women a right to reassignment or compensation in lieu if a worker presents a medical certificate attesting that working conditions may be dangerous to her unborn child, to herself by reason of her pregnancy, or to her nursing child, as the case may be. Compensation is paid on the same basis as it is paid under the general protective reassignment provisions, except that when payments are made out of the compensation fund, the cost is charged to all employers.¹⁴⁵ This is important because it avoids the creation of an additional economic incentive not to hire women capable of bearing children that otherwise might have resulted.

This right has proven to be particularly popular among Quebec women. It was initially expected that, when the program reached maturity, about 5 000 women annually would request protective reassignment and the cost to the compensation system would be about \$10 million to \$15 million annually.¹⁴⁶ This forecast seriously underestimated the number of requests and the cost. In 1989, 18 043 women applied for reassignment. Eighty-two percent of the requests were accepted, 16 percent were rejected, and 2 percent were still under consideration at the end of the year. Nearly \$50 million were paid out in benefits.¹⁴⁷ By 1991 the number of requests had increased to 20 642.¹⁴⁸

These provisions have been controversial from the employer perspective. They have been criticized on the grounds that the law is being abused by pregnant women who, with the complicity of their physicians, seek only an extended maternity leave. Management members on the CSST have argued that protective reassignment is really a social measure beyond the employers' responsibility and should be paid for out of general revenues.¹⁴⁹ Those writing from a feminist or progressive perspective have, on the one hand, criticized the limitations of the law and, on the other hand, defended it against employer allegations of abuse.

The earlier reviews focussed on the law's limitations.¹⁵⁰ First, the right arises only after a woman becomes pregnant. Protective removal to avoid reproductive harm earlier in the reproductive cycle is covered by the general protective removal provision but, because of the lack of knowledge and specific regulations, is unlikely to be effective. Second, limited knowledge about the effects of exposure to many, if not most, chemical, physical, biological, and psychosocial substances or conditions makes it difficult to determine whether the pregnant or breast-feeding worker is eligible for reassignment or compensation. The worker must prove on a balance of probabilities that there is a condition in her workplace endangering herself, her fetus, or her nursing child. Delays in making decisions may result in continuing exposure during a crucial period of development in which sensitivity is particularly high. Finally, legal rights are less likely to be invoked by workers who lack employment security even though the law offers protection against retaliation.

More recent studies have responded to employer criticisms of worker abuse. In regard to concerns expressed in respect of the increasing percentage of pregnant women in Quebec who apply for protective reassignment, Romaine Malenfant has demonstrated that this reflects the growth in the participation rate of women of childbearing age in the workforce.¹⁵¹ Another study focussed on the attitudes and working conditions of women who applied for protective reassignment. It found that leave was most likely to be taken by women who worked in sectors traditionally associated with risks. Moreover, the women who took leave reported their working conditions to be difficult more often than those who did not take leave. The study concludes that the popularity of the measure is not due to laziness or irresponsibility, but to poor conditions in women's traditional jobs.¹⁵² Finally, the position advanced by employers regarding the complicity of family doctors is questionable in light of the process followed in obtaining a certificate. These are not issued simply on the say-so of the woman's personal physician. Rather, consultations must be conducted with the community health department responsible for investigating conditions in the applicant's workplace, and the CSST must give its approval.

Perhaps the real problem is that employers have chosen not to improve conditions in order to accommodate the special needs of pregnant women. Perhaps this is because the cost of accommodation is borne exclusively by the particular employer, while the cost of compensation is spread out. One solution might be to consider establishing a fund to subsidize the cost of making accommodations, to which all employers would contribute.

D. Conclusion and Summary of Barriers

The coding of work injuries does not identify reproductive injuries per se. This makes them invisible within the system. Also, because workers' compensation data are used more generally by policy makers as an indicator of the level of health and safety in the workplace and to identify areas of particular concern, the absence of coding systems that facilitate the retrieval and analysis of data on particular harms should be a matter of great concern and the object of reform.

Workers' compensation does not cover third parties who are affected by the worker's injury. This includes children born with developmental disabilities attributable to a parent's work exposure and partners who may be harmed by substances brought home from work or who experience difficulty as a result of a partner's reproductive impairment. Workers' compensation coverage is not compulsory in some industries that were erroneously thought to be safe in the past.

The major barrier to compensation is the difficulty of proving work-related causation in non-traumatic cases. The causation barrier will continue to be a significant one even if a *best available hypothesis or significant contributing factor* test is adopted.

If causation is accepted, medical aid should cover the costs of treating the reproductive injury and its sequelae. Questions regarding the kinds of fertility treatment that should be covered and the counselling needed to assist reproductively injured workers in getting on with their lives will have to be answered as claims for these losses enter the system. Compensation for the loss of reproductive function itself or for negative reproductive outcomes (e.g., premature termination of pregnancy) at best are only sometimes partially compensated in some provinces. The question of what losses should be compensated in monetary damages is discussed in the conclusion.

The use of economic incentives to care based on claims cost experience is widespread but ineffective in relation to the prevention of reproductive harm in the workplace, because an insufficient number of claims have entered the system to make a difference. These mechanisms are at best reactive and for that reason unsatisfactory. At worst, they create economic incentives to discriminate against women who might be perceived to be more likely to suffer reproductive injuries and to make claims for them.

Penalty assessments based on observed hazards or safety audits could be used effectively to reduce the risk of injury and disease generally. They could also be used to target identified reproductive hazards. Protective reassignment with a right to compensation if no other suitable work is available can also be effective in preventing harm generally and reproductive harm in particular. Quebec has provided this right to all workers, but it is the provisions regarding the protection of pregnant and breast-feeding women that are the most beneficial. Other provinces provide much weaker rights to preventive compensation.

IV. Tort and Delictual Obligations

A. Private Law in Canada and Quebec

Two systems of private law exist in Canada: the civil law of Quebec and the common law of the rest of Canada. The background of Quebec's legal system is essentially French and civil and has been strongly influenced by Roman law and old French ordinances and customs, especially the Code Napoléon and the Code de procédure civile. However, because the Civil Code of Quebec operates in a North American environment dominated by the common law tradition, in many instances the interpretation of the Quebec code has departed from that of the French code.¹⁵³

Both the common law and the Civil Code of Quebec provide the basic principles and doctrines comprising the law of civil liability for personal injury. Thus, to determine and evaluate the availability of private law recourse for reproductive injuries arising out of employment, it is necessary to examine these regimes. In what follows we identify the types of injuries that may give rise to a civil action for reproductive harms suffered as a

result of workplace exposure and the potential plaintiffs who may be able to bring such claims. This exercise is necessarily speculative as there are no examples in Canada of successful civil actions for reproductive harms caused by occupational exposure to hazards.

After identifying the possible plaintiffs and types of harm, we discuss the bases of liability and the elements that must be established if a plaintiff is to succeed in a civil action. Because the two systems of private law in Canada are distinct, it is necessary to examine liability under the common law of tort and the civil law of delict separately. However, as will become evident, in certain areas the principles and doctrines of liability in the two systems are the same. This overview of civil liability for reproductive injuries concludes with the types of damages a plaintiff may be able to claim.

Following the overview of civil liability for reproductive hazards, the interaction between the workers' compensation statutory bar to civil recovery for workplace injuries and civil actions for damages arising from reproductive harms is discussed. And, finally, this section on civil liability concludes with an examination of actions for fetal harm or injury.

B. Injuries and Potential Plaintiffs

Various types of injuries to reproductive health can arise from a worker's exposure to occupational hazards. Not only can these injuries be classified in many ways, they may occur or become evident at different times: before conception, during pregnancy, and after birth.¹⁵⁴

Injuries occurring prior to conception may harm the reproductive health of the male or female worker, the worker's spouse, and/or the fetus or surviving child. Some of these impairments may be identifiable before conception (e.g., sterility, impotency, sperm and ova abnormalities, sexual dysfunction), and these may prevent or diminish the possibility of conception, impair maternal adaptation to pregnancy, or lead to a conception that later results in an adverse outcome. Some preconception injuries, such as chromosomal mutations in the ovum or sperm, may not be identified until manifested in adverse outcomes such as fetal loss, birth defects, chromosomal abnormalities in offspring, or genetically caused disabilities and susceptibilities. Preconception injury may also lead to other problems, including emotional distress for the worker, spouse, and offspring; loss of sexual and emotional companionship (consortium) for the worker and spouse; and even loss of parental companionship and resources for other children.

Reproductive injuries occurring during pregnancy may endanger the health of the fetus or complicate the pregnancy and endanger the health of the pregnant woman. These injuries may affect the fetus either before or after it is able to live outside the uterus and may or may not result in fetal loss. Like preconception injuries, these injuries may also result in loss of sexual and parental companionship, therefore resulting in harm to the pregnant worker's partner and any other children she might have.

Post-natal injuries within the context of the reproductive cycle are those that may harm the infant through exposure to an exposed parent, as where a parent brings home hazardous fibres on his or her clothing, or the mother's breast milk is contaminated by her exposure to a hazardous chemical.

The parties who may suffer these reproductive harms include the male and female worker; the worker's partner or spouse and living children; the embryo, fetus, or infant; and the descendants. The possible civil law causes of action for each of these parties are discussed in detail below.

C. Introduction to Tort Law

A tort is a civil wrong, other than a breach of contract, for which the common law provides a remedy. Because the law of tort covers a variety of interests, activities, and conduct, any single definition is of little practical assistance. According to Klar, "one may concede that despite its diversity, all the laws dealing with tort do in some way relate to wrongdoing, although the ambiguity of this concept turns all efforts at defining the law of torts in terms of wrongs into exercises of question-begging."¹⁵⁵

The most fruitful way to define the area of tort law is to distinguish it from what it is not. Unlike criminal law, where prosecutions are almost always brought by the Crown in order to punish the wrongdoer, tort is a form of private law. The plaintiff in tort law is responsible for bringing, maintaining, and paying for the litigation, subject to costs being awarded in his or her favour if the plaintiff is successful. The primary goal of tort law, unlike criminal law, is to compensate the plaintiff rather than punish the defendant. In contrast to criminal law, both tort and contract are varieties of private law; however, unlike contract law, where the duties are fixed by the parties themselves, the duties in tort derive from the common law.

The common law, as distinct from statutory law, comprises the body of rules and principles used by the courts in the absence of applicable legislation. It derives its authority from the judgments of courts. Canadian tort law is principally judge-made law, notwithstanding the growing encroachment of statutory modifications.¹⁵⁶ Since the common law is an adversary system, the parties have the sole responsibility of adducing evidence to prove their case.

1. Goals of the Tort System

Tort law is informed by a variety of stated and implicit goals. This is not surprising, as it is the product of judicial decisions issued over a long period of time. Different philosophies, contexts, and interests have shaped this area of law. However, it is possible, and helpful, to identify several goals of tort law against which the operation of this area of law may be evaluated.¹⁵⁷

Although the law of tort covers intentional conduct and matters other than losses caused by accidents,¹⁵⁸ the essential characteristic of tort law's primary area of operation is that it is a fault-based system of accident

compensation. Tort law redresses harms or injuries caused to plaintiffs by what the law defines as the unreasonable conduct of the defendant. Negligence, which is the area of tort law covering unreasonable conduct, covers conduct falling along a continuum ranging from the slightly substandard to grossly negligent or reckless behaviour.

Compensation has been identified as the primary goal of tort law. However, since there is no compensation without a finding of some fault on the part of the defendant, it is impossible to isolate the goal of compensation from the other goals of the tort system. Needy plaintiffs injured through no fault of their own will be denied compensation unless it is possible to identify a defendant whose faulty conduct caused the harm or injury.

The notion that the wrongdoer who injures another ought to be required to repair the damage and restore the victim is seen as a justice-based rationale for hinging compensation on a finding of fault. In other words, it is fair that the person who causes the damage ought to repair it. However, it is commonly acknowledged that the widespread availability of liability insurance compromises the justice dimension of tort law. Typically, the insurer controls the defence of the tort claim and compensates the victim, and the costs of compensation are distributed throughout the class of insureds. Thus, it is difficult to see how the wrongdoer pays for his or her wrong. In defending the justice dimension of tort law, most commentators point to the importance of the symbolic recognition of the value that the wrongdoer pay for the harm.

The symbolic aspect of a fault-based compensation system is the strongest argument for maintaining fault as a prerequisite for compensation. Although tort law has been justified on the grounds that the financial burden of compensation may deter the defendant or similarly situated actors, the existence of liability insurance renders this justification extremely controversial since it removes the financial burden of negligent conduct. Moreover, under tort law there is no necessary connection between the degree of fault of the defendant and the financial burden imposed. For example, reckless behaviour resulting in the death of a fetus or young child will result in but a moderate financial burden on the defendant (or the insurer), whereas slightly substandard behaviour resulting in permanent and total disability to a primary breadwinner will lead to a very large damage award. From the point of view of the victim, in most cases it is irrelevant who pays for the cost of compensation so long as she is compensated for her injuries.

2. Criticisms of the Tort System

The value of maintaining the existing system of fault-based compensation is extremely controversial. As one defender of the tort system acknowledges:

For every argument supporting the continued existence of a civil justice system in the area of compensation for personal injuries, there are

counter-arguments denigrating the goals, costs, utility, or effectiveness of the existing system.¹⁵⁹

Critics of tort law point to the problems in the litigation process — the high costs of bringing and defending actions, the difficulties of proof, the delays in the system, the speculative nature of damage awards, among others — to illustrate that the tort system provides neither an adequate system of compensation nor deterrence.¹⁶⁰ As well, they argue that the existence of the tort system undermines the possibility of devising a rational system to compensate victims of accidents and disease without regard to fault and complementary mechanisms designed to deter and punish actors whose conduct fails to meet social norms. Thus, critics of the tort system call for its abolition and the substitution of a comprehensive disability system in its place.¹⁶¹

While in Canada the tort system has shown surprising resilience to wholesale revision or abolition, there have been significant statutory modifications. This is particularly true in the area of work-related injuries or harms. Workers' compensation legislation is a form of legislatively mandated modification to the common law. The bar to civil actions by workers injured in the course of their employment makes tort litigation a difficult route for employees seeking compensation. In the majority of work-related injuries, the statutory bar precludes injured workers and their dependants from bringing a civil action. However, in some instances, workers may sue third parties, typically manufacturers, or seek punitive damages from their employers or third parties. The scope and effect of the statutory bar to civil actions for injuries sustained in the course of employment are complex and are discussed below.

Although tort actions are generally unavailable to injured workers, it is possible that the spouses or offspring of workers may themselves be exposed to reproductive harms via exposed workers. For example, workers may bring toxic substances from work into the household on their clothes, or through their own exposure they may transmit toxic substances to a developing fetus. Since spouses and offspring are not barred from suing in tort, these people may have a cause of action against employers. Moreover, they may also have a cause of action against manufacturers of any substance or product used in the work process alleged to have caused the harm.

D. Theories of Liability in the Common Law

There are two bases of liability that are relevant in the context of reproductive harms emanating from the workplace — battery and negligence. In essence, the degree of fault on the part of the defendant is what distinguishes these two grounds of civil liability.

1. Trespass to the Person and Battery

Trespass to the person occurs "where a plaintiff is injured by force applied directly to him by the defendant."¹⁶² Once the plaintiff proves that force was applied directly to him or her, the onus of trespass shifts and the defendant must show the absence of trespass or negligence. Of the various forms of trespass to the person, the most common is the tort of battery.¹⁶³

The tort of battery can be committed either intentionally or negligently. There are certain advantages to bringing an action in battery rather than in negligence if both are available. In battery, once the plaintiff proves there was a battery, the onus then shifts to the defendant to prove the injury occurred without his or her fault. Also, unlike negligence, where recovery for damages is limited by the principles of foreseeability and remoteness, in battery once the plaintiff establishes liability the defendant is liable for the entire damages resulting from her or his act.

Intentional battery is the intentional infliction upon the body of another of a harmful or offensive contact. The plaintiff need not be conscious of the physical contact at the time it occurred. A battery can be committed only when the defendant undertakes a positive act that causes physical contact. Most Canadian courts have confined the tort of battery to cases of directly caused injury. Moreover, battery requires that there be an "offensive" physical contact.¹⁶⁴ What constitutes offensive conduct is a question to be left to the trier of fact. Generally, conduct considered widely acceptable in society will not be considered offensive.

Negligent battery occurs when the defendant causes a direct, offensive, physical contact with the plaintiff as a result of negligent conduct.¹⁶⁵ Unreasonably disregarding a foreseeable risk of contact, even though the contact was not intended or certain to occur, constitutes negligent conduct. Although in an action for negligent battery the plaintiff does not have to prove negligence or damage, Klar states that these are seldom relevant considerations because the plaintiff is unlikely to bring a case where he or she has suffered no damage. Moreover, the matter of who has the burden of proving negligence will be a factor only if the trier of fact cannot come to a conclusion regarding negligence after the evidence has been heard.¹⁶⁶

In most cases of reproductive harms suffered as a result of occupational exposure it will be extremely difficult to establish either that the defendant intended to cause the physical contact that resulted in the harm or that the contact was direct. Battery actions would cover those situations where a customer, co-worker, employer, etc., physically strikes or interferes with a pregnant worker or where exposure to toxins results in damage to the fetus that is manifested after birth.

2. Negligence

Negligence is the failure to use such care as a reasonably prudent and careful person would use in similar circumstances. For an action in negligence to succeed, the following elements must be established on a balance of probabilities by the plaintiff:

1. A duty, recognised by law, requiring conformity to a certain standard of care for the protection of others against unreasonable risks. This is commonly known as the "duty issue."
2. Failure to conform to the required standard of care or, briefly, breach of that duty. This element usually passes under the name of "negligence."
3. Material injury resulting to the interests of the plaintiff...
4. A reasonably proximate connection between the defendant's conduct and the resulting injury, usually referred to as the question of "remoteness of damage" or "proximate cause."
5. The absence of any conduct by the injured party prejudicial to his [or her] recovering in full for the loss he [or she] has suffered. This involves a consideration of two specific defences, contributory negligence and voluntary assumption of risk.¹⁶⁷

2.1 The Duty of Care

The duty of care in negligence is based on a relationship of proximity between parties requiring one person to take reasonable care for the protection of others. *Donoghue v. Stevenson*¹⁶⁸ is the starting point for any discussion of the duty of care in negligence law. In it, Lord Atkin enunciated what has come to be known as the "neighbour principle" for determining what relations give rise to a duty of care:

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be — persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected by my act when I am directing my mind to the acts or omissions which are called in question.¹⁶⁹

It is important to note that the duty of care is limited by the notion of reasonable foreseeability. The notion of foreseeability is critical in negligence and is used not only as a factor in determining whether a duty was owed, but also whether it was breached, and whether the type of resulting injury ought to be the defendant's responsibility.¹⁷⁰ Foreseeability has been used in a variety of different ways, generally in an attempt to limit liability for the defendant's conduct. Courts have used foreseeability as a question of duty to mask what are essentially policy reasons for refusing to extend the scope of tort law. By characterizing foreseeability as a question of duty, and thus a matter of law, courts have been able to limit the extension of liability. If foreseeability was seen as simply a question to be considered in determining whether or not there was a breach of a duty, that question, which is a question of fact, would be left to the trier of fact — in many instances a jury.

A discussion of the extent to which policy decisions may explicitly limit the duty of care owed by a particular defendant to a particular plaintiff is

beyond the scope of the present discussion. While a duty of care may arise in a range of situations, of particular concern for the analysis of the availability of tort actions for reproductive injuries arising out of work is the duty of care owed by a products manufacturer. This is because most claims for compensation for reproductive injuries to workers, or injuries caused to the spouses and offspring of workers through exposure to reproductive hazards, will arise in situations where the employer is producing or using substances or processes that may cause such hazards.

2.1.1 Duty of Care Owed by Employers

The employment relationship clearly falls within the class of relationships considered sufficiently proximate for a duty of care to be imposed by law. In addition, at common law, employers are under an implied duty to provide a safe workplace for their employees. Because of the close connection between contract and tort law in requiring safe workplaces, the discussion of the employer's duty of care is postponed to that part of the study addressing employment law.

2.1.2 Products Liability

Products liability is composed of the set of principles that govern a product seller's responsibility for harm caused by its products. The law allows persons who are injured because of exposure to a defective and dangerous product to seek compensation for their injuries from anyone who participated in placing the product into the stream of commerce, including the manufacturer, wholesalers, and retailers. The defect may be in the design itself¹⁷¹ or it may be caused through negligence in the production process.¹⁷²

2.1.3 Standard of Care

In *Donoghue v. Stevenson*,¹⁷³ Lord Atkin spoke of the duty imposed on the manufacturer to take reasonable care. In Canada, the standard of care in products liability cases has been stated as the "the duty to use reasonable care in the circumstances and nothing more."¹⁷⁴ A court will determine what constitutes reasonable care in light of the knowledge available at the time of the alleged breach of duty.

Prior to *Donoghue v. Stevenson*, the courts imposed a special duty of care regarding things dangerous in themselves, such as guns or explosives. However, *Donoghue v. Stevenson* eliminated the dichotomy between products dangerous in themselves and all other products. Today, the distinction is relevant only to the extent it assists the court in formulating a standard of care taking into account the aggravated risk associated with the use of a dangerous product.¹⁷⁵

A breach of a statutory standard does not give rise to a cause of action for a breach of a statutory duty. Breach of a statute is relevant, however, as evidence of negligence.¹⁷⁶ Similarly, compliance with legislative requirements will not necessarily relieve the manufacturer from meeting a higher standard of care in certain circumstances. Moreover, compliance with

legislation does not replace the common law duty to warn of risks attendant upon the use of a product.¹⁷⁷

A court will consider whether the industry standard at the time the product was manufactured¹⁷⁸ and the product itself were defective with respect to the state of the art at the time. A defendant who follows industry practice may nonetheless be found negligent where the court finds the practice to be inadequate.¹⁷⁹

Manufacturers' duty to take reasonable care in the circumstances requires the manufacturer to warn users of the danger or risk of injury inherent in the nature of the product or attendant on its use.¹⁸⁰ The duty to warn embraces dangers that are known,¹⁸¹ or ought reasonably to be known,¹⁸² to manufacturers in the use of their products, that is, dangers that are reasonably foreseeable. The test for determining the adequacy of the warning is: What is a fair and reasonable warning in all of the circumstances of the case?¹⁸³ The required explicitness of the warning varies with the degree of danger likely to be encountered in the ordinary use of the product. The more hazardous the product and the greater the likelihood of harm, the greater is the duty on manufacturers to provide a clear, explicit, and comprehensive warning.¹⁸⁴ It is important to note, however, that manufacturers are not required to perform tests to identify possible defects or to determine potential hazards that are commercially unfeasible.¹⁸⁵

A manufacturer has a duty to warn of inherent dangers resulting from negligent design or manufacture, dangers involved in using the product in certain circumstances or ways, or inherent, unavoidable risks to the unusually susceptible consumer of generally safe products.¹⁸⁶ The failure to warn must cause or materially contribute to the plaintiff's injuries. If the plaintiff would have used the product having full knowledge of the risks, there is no causal connection between the two events. Thus, plaintiffs must show that an adequate warning would have influenced their behaviour.

Negligence may occur in a multitude of contexts in which reproductive risks are generated, including:

- i. the design, operation, maintenance, or monitoring of workplaces where reproductive hazards are present; and
- ii. the design, testing, construction, inspection, quality control, or labelling of products posing reproductive risks, or the provision of warnings or instructions for their safe use.

2.1.4 Proof of Negligence

Once the plaintiff proves that the product was defective and that the defect caused her injuries, she must prove that the manufacturer was negligent. Where there is no direct evidence of negligence, the plaintiff may invoke the doctrine *res ipsa loquitur* (the thing speaks for itself) to assist her in proving her case. This is a rule of circumstantial evidence rather than one of substantive law.

Proving negligence or fault in the context of reproductive hazards will be extremely difficult to do unless the manufacturer is in breach of statutory standards or industry practices regarding testing, exposure levels, warnings, or hygienic policies and practices. Although industry customs and practices do not constitute a complete bar to a finding of negligence, it is extremely unlikely that a court will find a manufacturer at fault in the absence of flagrant disregard of what is deemed acceptable in the industry.

2.2 Legal Causation

To prove legal causation of an injury or harm, the plaintiff must show the existence of a chain of events or facts that, taken together, are deemed legally sufficient to show it is more likely than not the plaintiff was injured by the defendant's breach of the duty of care owed to the plaintiff.

The House of Lords decision in *McGhee v. National Coal Board*¹⁸⁷ relieved somewhat the burden of causation for the injured worker. That case held that if the plaintiff shows a breach of a duty by the defendant, which creates an unreasonable risk followed by an injury in the area of risk, then that is sufficient to show *prima facie* proof of causation. However, subsequently the House of Lords warned that the principle in *McGhee* (reverse onus approach) should not be interpreted too broadly. In *Wilsher v. Essex Area Health Authority*¹⁸⁸ the House of Lords made it clear that merely being a possible cause of the plaintiff's injury is sufficient neither to establish causation nor to shift the burden of proof to the defendant. Instead, in the context of the evidence, it may lead to an inference of causation.

In Canada, it is unclear whether the *McGhee* reverse onus approach or the *Wilsher* inferential reasoning approach is preferred by the Supreme Court of Canada.¹⁸⁹ In *Snell v. Farrell* the Supreme Court noted that the principles of proof must not be applied too rigidly and that causation was a practical question of fact.

Regardless of which approach is adopted in Canada, plaintiffs who allege reproductive harm as a result of the negligence of their employer face the onerous burden of proving causation. First, it will be difficult for them to obtain information essential to proving the case. The employer will control the data on the level of workplace exposure to the substance, if such records were even maintained. Exposure levels safe for the average worker and compliance with the legislation may be regarded as reasonable and therefore the onus will not shift even if the *McGhee* approach is adopted.¹⁹⁰

Moreover, even if it is possible to determine the substances to which a plaintiff is exposed and their levels, it still will not be an easy matter to establish causation. According to the United States' Office of Technology Assessment:

The greatest obstacle to recovery for any reproductive harm against any of the potential defendants under any of the theories of liability is proof that exposure to one or more hazards was more likely than not a sub-

stantial factor (though not necessarily the only factor) in causing the particular reproductive injury for which monetary damages are sought.¹⁹¹

The specific events and facts to be proven will generally require the plaintiff to give evidence of:

- hazardousness of the substance (e.g., mutagenicity, teratogenicity, toxicity);
- emission of the substance in the workplace (e.g., levels, duration);
- plaintiff's exposure to the substance (e.g., level, duration, type of exposure);
- plaintiff's uptake of the substance (as measured in blood, urine, etc.);
- biological response after plaintiff's exposure (e.g., blood level, chromosomal change); and
- plaintiff's reproductive injury.

A plaintiff who fails to establish any one of these facts will generally lose in the tort action. This creates an almost insurmountable burden for plaintiffs who wish to obtain compensation for reproductive harms resulting from negligent exposure to hazards in their workplace. Moreover,

because each of these facts may involve considerable medical and scientific uncertainty, the practical problem of proving legal causation by a preponderance of the evidence can be a formidable and costly procedure requiring the testimony of several scientific and medical experts.¹⁹²

Typically a plaintiff will need to cite testimony from a physician or other medical or scientific experts, epidemiological data, animal studies, and other information to draw convincing inferences regarding the cause of a reproductive injury. The judicial response to epidemiological and toxicological evidence is sceptical. Epidemiological and toxicological evidence is used as building blocks to establish causation in a particular case; by itself such evidence cannot establish causation in a particular case.¹⁹³

Proof of a causal connection between exposure to a reproductive hazard and a reproductive injury or harm is further exacerbated by the dearth of knowledge about industrial diseases in general and their impact on reproductive functions in particular. Moreover, it is extremely difficult to isolate the impact of environmental and genetic factors from occupational hazards in accounting for the causes of reproductive harms.

2.3 Defences

(a) Voluntary Assumption of Risk

An agreement to accept the risks of unreasonable conduct can be made implicitly or explicitly. Where the plaintiff has actual knowledge of a defect or danger in the product but proceeds to use it, she may be held

to have assumed the consequential risk of injury. The onus is on the defendant to establish that the plaintiff appreciated the risk involved and made a conscious choice to assume it, thus exempting the defendant from liability. This operates as a complete defence.¹⁹⁴

In an employment setting, however, it will be a difficult burden for the defendant to establish that the plaintiff voluntarily assumed the risk. The defendant must establish that the plaintiff accepted the risk of being injured in his or her employment. Moreover, in certain situations, it is possible that while the plaintiff accepted the physical risk of injury, she or he did not accept the legal risk.¹⁹⁵ The inequality of bargaining power characterizing the employment relationship in most cases would negate an assumption that the employee voluntarily assumed the risk. Moreover, as is discussed below, the workers' compensation legislation in most jurisdictions has abolished the defence of voluntary assumption of risk in the employment setting.

However, it is possible that a plaintiff could have entered into an express agreement to accept the risk of injury stemming from the defendant's unreasonable conduct. In such a case, the validity of an exemption clause (also known as a waiver of liability) will be determined as a matter of contract law.¹⁹⁶ As with contractual exemption clauses, these express agreements will be interpreted strictly. Moreover, to rely on an express exemption of liability, the defendant must demonstrate the clause was drawn to the plaintiff's attention and that the plaintiff appreciated its import.

Since exemption clauses are characterized as a matter of law as a contractual arrangement, the doctrine of privity will apply. According to the doctrine of privity, only parties to the agreement are bound at law by it and only the parties can resort to law to enforce it against each other. For this reason, an employee cannot limit the liability of a defendant employer for negligence actions that may result in harm to a third party. Thus, for example, an express agreement in which the employee waives the right of any offspring to claim damages resulting from fetal exposure would be unenforceable.

(b) Contributory Negligence

To be guilty of contributory negligence the plaintiff must foresee harm to herself.¹⁹⁷ Contributory negligence arises from the failure to take such care as the circumstances require, and it involves a causal connection between the plaintiff's negligence and her injuries. The burden of proving the necessary causal connection lies on the defendant. The plaintiff's negligence, to be contributory, must be proximate.

Unlike the defence of voluntary assumption of risk, contributory negligence does not operate as a complete bar to recovery. Under the relevant negligence legislation of the jurisdiction, the obligation is on the court to apportion the damages in proportion to the degree of fault or negligence found against each of the responsible parties. Where the court cannot

determine the degree of fault or negligence applicable to each party, they are deemed to be equally at fault.

2.4 Damages

Damages awarded out of a successful tort action can be divided into two general categories: compensatory and non-compensatory. The purpose of compensatory damages is to restore the plaintiff to the situation that he or she would have been in but for the defendant's tortious conduct. Non-compensatory damages, whether they be punitive, aggravated, or exemplary, are designed to deter or punish the defendant for egregious behaviour.

(a) Compensatory Damages

These damages are divided into two general categories: special and general. Special damages include all the expenses that the plaintiff is out of pocket before the end of the trial. General damages, on the other hand, have a prospective effect. General damages can be subdivided into two categories: pecuniary and non-pecuniary. Pecuniary damages include loss of future income and cost of future care or treatment. Non-pecuniary damages are awarded for the loss of intangibles and include damages for pain and suffering, loss of enjoyment of life, and loss of amenities.

(b) Pecuniary Damages

Under the heading of special damages the plaintiff is entitled to be compensated for all out-of-pocket expenses (that would not have been incurred but for the injury) incurred between the time the injury or impairment was suffered and the date of trial. This includes the costs incurred by the plaintiff incurred for treatment of the reproductive impairment or any psychological distress arising from the impairment. Moreover, under the heading of general damages, the plaintiff is also entitled to the cost of future care or treatment that is reasonably expected to facilitate recovery or to allow the plaintiff to cope with the injury.

To the extent that the reproductive impairment or injury negatively impacts on the plaintiff's income-earning capacity, the loss of future earnings, or any loss of earnings prior to trial, the plaintiff will be compensated. Loss of earnings will typically be limited to those cases where the plaintiff has to temporarily forgo employment to undergo treatment. However, there may be some cases where a psychological condition resulting from the physical impairment, such as depression, will interfere with the plaintiff's income-earning capacity. If this can be established, the plaintiff is entitled to compensation.¹⁹⁸

In the event that fetal exposure to workplace hazards results in disability to the surviving child, the non-pecuniary damage claim could be quite high as it will include the cost of future care and the loss of future earnings. This is particularly the case where the child is severely disabled as a result of the negligent exposure.

(c) Intangible Injuries Resulting from Reproductive Hazards

Non-pecuniary loss refers to the intangible losses sustained by the victim of injury. They include physical or mental impairment, pain and suffering, the inability to enjoy activities previously enjoyed, and any reduction in life span caused by the injury. The courts have adopted a functional approach to the assessment of non-pecuniary damages that attempts to assess the sum required to make the injured party's life more endurable.¹⁹⁹

In determining the extent of the plaintiff's non-pecuniary loss, the court looks to the following factors: (i) pain and suffering, (ii) loss of amenities, and (iii) loss of expectation of life. The first two are relevant to reproductive injuries. Pain and suffering refer to the actual pain and mental distress suffered by a plaintiff as a result of an injury, while the loss of amenities refers to the injury itself and the effect of the injury on the plaintiff's activities and enjoyment of life. Moreover, damages will be awarded for pain and suffering and loss of amenities caused by the victim's psychological reaction to the injury.²⁰⁰ Thus, both occupationally induced physical injury (e.g., miscarriage, sexual dysfunction and impairment) and the psychological effects of such injuries (e.g., depression) can be compensated under the heading of non-pecuniary damages.

In a leading compilation of damages for personal injury and death,²⁰¹ no cases for reproductive harm resulting from non-traumatic injuries were listed. There were, however, many examples of damage awards to both men and women for reproductive harms caused by traumatic injuries. For example, a 20-year-old man whose right testicle was severed, resulting in total sterility, was awarded \$9 450.²⁰² A 20-year-old woman whose severe abdominal injuries necessitated a hysterectomy with the consequent loss of an unborn child was awarded \$25 000.²⁰³

(d) Loss of Consortium

Loss of consortium is a legal term applied to the loss incurred by a spouse when a marital partner suffers a personal injury. Loss of consortium encompasses any diminution or impairment of marital companionship, affection, and sexual relations. Reproductive or sexual impairment could lead to a claim for loss of consortium. In some jurisdictions, Ontario for example,²⁰⁴ actions for loss of consortium are barred by statute. However, in Alberta, for example, it is still possible for a spouse to bring an action for loss of consortium.

At common law, actions for consortium were limited initially to the husband claiming for damages as a result of an injury to his wife.²⁰⁵ In *Best v. Fox*,²⁰⁶ the House of Lords regarded an injury to a wife as an injury to the husband because of the husband's proprietary interest in his wife. Initially, actions for loss of consortium were confined to intentional harms, but they were gradually extended to include negligent harms. It is unclear whether a husband may claim damages resulting from loss of consortium from partial incapacity (e.g., sexual performance) or whether such claims

were limited to cases of complete incapacity. High among the non-pecuniary items is loss of sexual relations, which is considered "material" and deserving modest awards.²⁰⁷ Mere distress at the condition of one's spouse is not compensable.

In *Best v. Fox* the House of Lords defeated a wife's bid for loss of her husband's consortium, including sexual incapacity. This case has been followed in Ontario.²⁰⁸ The old common law never recognized a right in a wife to services from her husband corresponding to his right to services from his wife. A wife was entitled only to a parasitic action for loss of consortium, such as in cases where the wife is disfigured or made infertile and the husband leaves. The wife's non-pecuniary damages go completely uncompensated. Since a husband's action for loss of consortium is generally considered an anachronism, typically the wife's action has not been extended, but rather the action for loss of consortium has been abolished. In jurisdictions where damages for loss of consortium have been retained, women typically have equal rights to men.²⁰⁹

(e) Non-Compensatory Damages

The plaintiff may, in exceptional cases, be awarded either aggravated or punitive damages.²¹⁰ Aggravated damages are intended to compensate the injured feelings of the plaintiff, whereas punitive damages are designed to punish the defendant. The latter are usually awarded in respect of trespass to the person or in actions involving some high-handed, outrageous conduct, or where the defendant would make an unseemly profit from his wrongdoing if he were required to pay compensatory damages only.

The intention of the defendant is the key to an award of punitive damages. If the defendant is subject to criminal proceeding, there is typically no award of punitive damages, although there is no bar to the award of punitive damages in such circumstances.

Where negligence is the cause of action, it is very unusual for punitive damages to be awarded. Before such damages are awarded for a negligence action, there must typically be something more than just negligence.²¹¹ Generally, there must be proof of entire want of care or reprehensible conduct.²¹²

In determining the amount of punitive damages, the gravity of the defendant's conduct and the defendant's means are relevant. Unlike the United States, in Canada awards for punitive damages are generally limited to less than \$10 000.²¹³

E. Civil Responsibility or Delict in Quebec

1. Overview of Civil Responsibility and Delict in Quebec

The Civil Code was enacted in Quebec in 1866. The code covers almost the entire private law of the Province of Quebec, and its rules are stated in general terms to promote flexible interpretations to meet changing social conditions.²¹⁴ The field of responsibility, which covers the common

law system of torts and negligence in a wider way, has been amended only three times since 1866, and on each occasion the changes were minor.

This does not mean, however, that the Quebec law of civil responsibility or delict is static. On the contrary, like the common law, changes in terms of liability have come from judicial interpretations of the articles, rather than from legislative amendment.²¹⁵ The basic principle of liability is contained in Article 1053, which states that:

Every person capable of discerning right from wrong is responsible for the damage caused by his fault to another, whether by positive act, imprudence, neglect or want of skill.

Unlike the common law, Article 1053 makes no distinction between intentional and negligent harms. This provision is supplemented by Article 1054, which establishes a presumption of liability of those who have care or control of objects.

Thus, unlike the common law, which originally established specific torts, the civil code system of liability began from a statement of general principle. But, ultimately, the goals of the common law of tort and the civil law of delict are the same: "To select out of the enormous range of daily occasions when harm is caused those where ... the victim should be allowed to transfer the loss to the defendant."²¹⁶

Because the system of liability is embodied in a code, interpretative techniques different from those used in the common law have developed. However, it is important to recognize the extent to which the Quebec law of delict has been influenced by common law.²¹⁷

This influence has been indirect rather than direct because the rule is that English common law decisions can be of value in Quebec civil cases only when it has been ascertained that in the law of England and the law of Quebec the principles on which the particular subject matter is dealt with are the same and are given like scope in their application. Even then they do not function as binding precedents.²¹⁸

Despite this, like the common law, the Quebec code is more insistent on the notion of fault than the French code: the Quebec code substituted fault for the French notion of "fait," which imposes responsibility from the mere act of the agent without a finding of fault, in nearly all the articles dealing with personal or vicarious responsibility. It follows that in Quebec the whole system of responsibility is reluctant to admit a liability occurring from the mere act of the agent, without there being demonstrated, first, the fault on which the act rests. As we shall see, both the common law and civil law systems have moulded the notion of fault similarly.

1.1 Article 1053 — The General Principle of Liability Based on Fault

In the Province of Quebec, to succeed in an action for damages for breach of a delictual or quasi-delictual obligation, the plaintiff must establish to the satisfaction of the court:

1. The fault of the defendant

2. The damage sustained by the plaintiff
3. A causal connection between fault and damage.²¹⁹

There have been many attempts to define fault. According to Crépeau, fault may be broadly defined as: "A violation of one's pre-existing duty whether it be one voluntarily assumed by contract (contractual obligation) or one imposed by law (legal or extra-contractual obligation)."²²⁰

Article 1053 has been interpreted as presupposing a subjective capacity to foresee the damage that will result and avoid it. Thus, similar to common law, the notion of foreseeability is essential for establishing liability under the Quebec civil law system.²²¹ Moreover, someone is objectively at fault when he or she has failed to exhibit the standard of care expected of him or her by the courts. This standard is an abstract one that does not vary from individual to individual. It is expressed as *bon père de famille*, which means that so long as people act with the skill and care expected of a reasonably careful and prudent person in the circumstances of the case, they will not be responsible for the resulting damage.²²² The standard of care required under the civil system of delict is very similar to that in the common law of negligence.

It is the plaintiffs who must prove the objective element of fault. Their obligation with regard to the burden of proof might be described by saying that they must prove a set of external facts that will amount to a fault when combined with the subjective situation that the courts will infer from those facts in the absence of proof to the contrary.

1.2 Article 1054 — Responsibility for Things Under One's Care

Article 1054, which states that "he is responsible not only for the damage caused by his own fault, but also for that caused by the fault of persons under his control and by things which he has under his care," would appear to be a significant departure from the fault-based system of the common law in the area of products liability in particular. However, as we shall see, judicial interpretation of the Civil Code of Quebec has cleaved closer to the common law of England than to the civil code of France.

The first issue to resolve is whether Article 1054 imposes strict liability for damage caused by things under one's care or whether it operates like the evidentiary presumption of *res ipsa loquitur* in the common law. Initially, the Privy Council interpreted Article 1054 as providing the latter²²³ (i.e., in the absence of proof of fault, the defendant would be presumed to have been at fault unless she or he could offer another reasonable explanation). However, four years later, the Supreme Court of Canada interpreted Article 1054 as eliminating entirely the need to prove the defendant's fault in cases of damage caused by things under the defendant's care.²²⁴ In the absence of proof that the damage was caused by the plaintiff's fault or that it was a case of pure accident, a defendant must be held responsible for damages shown to have been caused by things under his or her care. The Supreme Court's decision mirrored, in effect, the liability imposed in France for things under one's care, which permits

care, which permits the defendant to escape liability only insofar as she or he succeeds in demonstrating that the damage was caused by a fortuitous event or the irresistible force of the fault of the victim or a third party.

Faced with these two poles of liability and the need to respect the integrity of the Civil Code, the Privy Council ultimately adopted a mid-position. It interpreted Article 1054 as

[introducing] a new liability ... all of which are independent of that personal element of faute which is the foundation of the defendant's liability under art. 1053. Furthermore, proof that the damage has been caused by things under the defendant's care does not raise a mere presumption of faute, which the defendant may rebut by proving affirmatively that he was guilty of no faute. It establishes a liability, unless, in cases where the exculpatory paragraph applies, the defendant brings himself within its terms. There is a difference, slight in fact but clear in law, between a rebuttable presumption of faute and a liability defeasible by proof of inability to prevent the damage.²²⁵

What the Court did in *Quebec Railway, Light, Heat and Power Co. v. Vandry* was to interpret the first paragraph in Article 1054 as imposing strict liability, subject to the exculpatory paragraph later in the same article. Under Article 1054, "the responsibility attaches in the above cases only when the person subject to it fails to establish that he was unable to prevent the act which has caused the damage."

The application of the exculpatory paragraph to the first paragraph of Article 1054 was reaffirmed by the Privy Council and extended to limit the defendant's liability in *City of Montreal v. Watt and Scott Ltd.*²²⁶ In that case the Privy Council held that a defendant is presumed to be liable for any damage caused by objects or things under his or her care unless he or she can demonstrate he or she was unable to prevent the damage by reasonable means. According to this interpretation, fault still operates under Article 1054; however, the defendant has the burden of proving absence of fault, rather than the plaintiff having to establish fault as in the common law of tort. Tactically, this means a defendant has to adduce evidence establishing that there was nothing reasonable he or she could have done to prevent the damage or that something else caused the damage. In this way, it is easier under the civil law of Quebec for a plaintiff to establish liability in cases of latent defects or other things under the defendant's control than it is under the common law. However, the courts have developed other techniques to limit liability under Article 1054.

In Quebec, the presumption in Article 1054 applies only in those cases where damage was caused by a thing without the immediate intervention of humans. If the damage is caused by the misuse of a thing, then the plaintiff must establish fault under Article 1053. If, however, the damage is caused by a latent defect, then Article 1054 applies.²²⁷ This distinction is crucial and it is a question of fact.

In the context of reproductive hazards in the workplace, it is likely that Article 1054 would operate to the extent the harm is caused by exposure

to toxic substances. However, since the plaintiff has a more difficult case to establish if the damage is caused by human intervention, it is also likely that defendants would attempt to characterize high exposure levels, for example, as a result of human misuse rather than a latent potential of the substance. However, since Article 1054 has been broadly read as applying to liquids, electricity, and gases, it is arguable that it should apply in cases involving non-accidental exposure to toxins.²²⁸

To summarize, when damage is caused by a thing under the defendant's care, direct liability is created independently of any allegation or proof of fault. To escape that liability, defendants must first show how the damage was brought about, and, to bring the exculpatory clause into play, they must prove that the act causing the damage was one that they were unable to prevent by reasonable means. The plaintiff must prove the damage was caused (a) by the thing in question within the meaning of Article 1054 and (b) at the time the thing was under the defendant's care. If a plaintiff is unable to establish either (a) or (b), she or he can seek to establish liability under Article 1053.

1.3 Legal Causation

As in the common law, the issue of causation creates the greatest hurdle for obtaining compensation for occupational reproductive hazards through the civil law of delict. The defendant is liable only for that damage which is a direct and immediate cause of her or his fault.²²⁹ The damage suffered by the plaintiff must have been caused by the fault of the defendant. The burden of proving causation is on the plaintiff (Article 1203), except when the defendant's fault is presumed. According to Article 1053, when a plaintiff proves the defendant's imprudence, neglect, or want of skill, by the same token she or he proves the causal connection between the defendant's acts and the breach of the defendant's obligation of prudence and diligence. According to the Supreme Court of Canada, "the conception of 'cause' in article 1053 of the Civil Code does not differ, in a case of this nature, from that of the Common Law."²³⁰ Thus, any act or circumstance without which the damage would not have been incurred by the plaintiff is a legal cause.

Moreover, like the common law, the Civil Code of Quebec imposes joint and severally liability on all persons who caused the damage. According to Article 1106, if several faults contributed to the damage, they are all causes, and the persons who committed them are jointly and severally liable.

As was indicated in the discussion of causation in the common law, proof of causation in the context of occupational reproductive hazards will be extremely difficult to establish. The same sorts of problems arising under the common law will operate under the civil law of Quebec because the conception of legal causation under both systems is virtually identical.

1.4 Exemption Clauses

It is possible for the defendant to exempt liability under Article 1053. However, the criteria for upholding an exemption in personal injury cases are very high.²³¹ Under Article 1054, manufacturers are not allowed to exclude their liability through an exemption clause. This is because the courts have recognized a strict presumption of knowledge of the latent defect of the product.²³²

1.5 Defences

Defendants in actions based on Articles 1053 and 1054 can always prove they were not at fault or that there was no relation of cause and effect between their fault and the damage. This negative proof is very difficult. In most cases, it is much easier for defendants to prove the damage was due to a cause that could not be imputed to them, such as the sole fault of the plaintiff or the fortuitous event (one that is unforeseen and caused by a superior force impossible to resist: Article 17(24)). In some instances, however, both the plaintiff and the defendant may have contributed to the damage, and the problem is one of common fault. When the defendant alleges common fault on the part of the plaintiff, it operates in much the same way as contributory negligence.²³³

In addition, there is within the civil law of Quebec a defence that is virtually the same as the common law notion of voluntary assumption of risk. It is known as *volenti non fit injuria*. To succeed on *volenti*, defendants must establish that the plaintiffs freely and voluntarily, with full knowledge and appreciation of the risk they ran, implicitly agreed to incur it.²³⁴

1.6 Damages

A plaintiff is only entitled to claim damages which are an immediate and direct consequence of the breach of the obligation (Article 1075). The assessment of personal injury damages under the civil law of Quebec follows the same principles as the common law. As noted above in the discussion of the common law, in *Andrews v. Grand & Toy Alberta Ltd.* the Supreme Court of Canada established some criteria for the assessment of personal injury compensation. *Andrews* has been followed by the Quebec Court of Appeal on several occasions and is the law of Quebec.²³⁵ Like the common law, and unlike the law in France, Quebec courts refuse to award damages for purely moral bereavement or sorrow (*solatium doloris*).²³⁶

1.7 Discussion

Where available, civil actions will likely provide a difficult route for a plaintiff to obtain compensation for damages resulting from reproductive injuries in the workplace. The primary hurdles will be establishing a breach of the standard of care and legal causation. Even if these hurdles are overcome, the damages for reproductive harms (with the exception of damages for children disabled as a result of prenatal exposure in the workplace) are likely to be moderate. Thus, even in cases where the manufac-

turer does not have liability insurance, civil liability provides little incentive for employers and manufacturers to provide working environments that minimize the possibility of reproductive harm.

F. Interaction of Workers' Compensation Statutory Bar and Civil Actions

As noted above in the discussion of workers' compensation legislation, the general principle in jurisdictions across Canada is that no claim in respect of a compensable disability lies by court action against the employer of the injured worker, any worker of that employer, any other employer covered by the act, or any worker of such other employer.²³⁷ In effect, this means that if a manufacturer of a product is an employer under the relevant workers' compensation legislation (typically a manufacturer in the province), products liability suits will also be barred against that manufacturer. However, if the manufacturer is located outside of the jurisdiction, there is a potential for a products liability action. This possibility is discussed below in exceptions to the statutory bar.

For a claim to be barred, it must relate to some act or omission of a worker in the course of employment, or of the defendant in the course of business as an employer. The statutory bar applies whether the cause of action is alleged to rest in a common law tort, a contract, or a breach of a statutory duty, and it applies whether the employer or worker is sued as a defendant or has been joined as a third party.

There have been several attempts to invoke the *Canadian Charter of Rights and Freedoms*²³⁸ to defeat the bar to civil actions for injuries arising out of the course of employment. Some such cases have related to claims against the employer of the injured worker, and others have involved claims against a different employer. To date, the statutory bar to civil actions has been sustained in both cases.

In *Reference re Workers' Compensation Act, 1983 (Nfld.)*,²³⁹ the Supreme Court of Canada unanimously held that the statutory bar to civil actions arising out of injuries in the course of employment did not violate equality rights provisions contained in s. 15 of the Charter. Moreover, in *Budge v. Workers' Compensation Board (Alberta) (No. 2)*,²⁴⁰ the Alberta Court of Appeal held that the bar to the right to sue does not offend s. 7 of the Charter. The court stated that the right to sue for injuries suffered in the course of employment was a purely economic right, and thus not a liberty right within the meaning of s. 7. In so deciding, the court stated that

the foregoing should be read in context. It has to do with a statute which replaces common law liability with a special scheme of compensation much like insurance. So it does not bar all recourse. It does not pardon or legalize tortious conduct, still less deliberate conduct.²⁴¹

1. Actions by Employees Against Their Employer

1.1 Coverage of the Workers' Compensation Act

The act applies automatically and the coverage is compulsory for most employment. In some jurisdictions, this is achieved by applying the coverage to all employers and workers engaged in an industry of a type listed in the act or in a regulation. These lists generally include all known manufacturing, construction, and extraction industries and the distributive trades. Crown employees and other types of public servants and employees are generally included, but with substantial exceptions. In some cases, there is also a list of exclusions.

Examples of industries typically excluded from coverage under the workers' compensation legislation are entertainment, insurance, law, medicine, accounting, and dentistry. Domestic service has generally been excluded, but the contemporary trend is to bring some of it within the compulsory coverage. The rationales for these exclusions are discussed briefly in the section on workers' compensation.

1.2 Employers Who Have Failed to Register with the Workers' Compensation Board

There is an additional complication when someone falling within the statutory definition of an employer has not registered with the board or paid assessments. In such cases, a defendant in a lawsuit is claiming employer status when it had not, prior to the accident, accepted the status under the act. In British Columbia, the board held that the alleged employer cannot claim to be an employer under the act to claim the statutory bar when it had earlier claimed a different status to avoid the obligations of the act.²⁴²

By contrast, in Ontario, the Appeals Tribunal allowed the statutory bar to apply in a similar situation.²⁴³ According to Ison, the British Columbia approach is preferable because it prevents an employer from claiming the statutory bar without paying assessments, at least until a serious accident or injury occurs.²⁴⁴ To hold otherwise would be to create an incentive for employers, especially small employers, to avoid registering with the board.

1.3 Civil Actions in Industries Not Covered by Workers' Compensation Legislation

If the employment is not covered by the workers' compensation system, an employer may be liable to an injured worker in an action at common law for damages for negligence.²⁴⁵ Earlier common law doctrines relating to employers' liability have been modified in some jurisdictions, usually in Part II of the Workers' Compensation Act.

The most important modifications of the common law doctrines are²⁴⁶:

- (i) the addition of strict liability for defects in the works, machinery, premises,
- (ii) abolition of the defence of common employment, and

(iii) abolition of the defence of assumption of risk.

The addition of strict liability for defects for employment-related injuries and harms should make it easier for employees to succeed in civil actions against employers since they will no longer have to prove that the employers' actions or omissions were unreasonable in the circumstances. Despite alleviating the employee's burden to a certain extent, in cases of reproductive harm difficulties will arise in establishing a defect — especially in cases where the employer adheres to the industry or statutory standards — and proving legal causation.

1.4 Punitive Damages

There is mixed case law as to whether the bar applies to gross or wanton behaviour on the part of the employer. In Saskatchewan, the statutory bar operates to preclude civil actions arising out of alleged gross or wanton misconduct.²⁴⁷ Similarly, the Nova Scotia Court of Appeal recently held that the statutory bar precludes an independent right of action against the employer for damages, exemplary or otherwise.²⁴⁸ This holding reverses a decision of the lower court that held that, although the statute barred compensatory damages, exemplary damages could be claimed in a civil action where the employer has shown wanton disregard or outrageous and callous indifference for the health and welfare of the plaintiff. The rationale for making the distinction was that the purpose of workers' compensation was to provide compensatory damages, not to punish, and therefore the statute should be interpreted to permit actions for punitive damages. In brief oral reasons, the court of appeal reaffirmed the more traditional effect of the statutory bar.

In Quebec, the court of appeal interpreted the statutory bar to civil actions for injuries arising in the workplace as designed to prevent actions for compensation caused by the injury to the physical or psychological integrity of the worker. Thus, the court held that Article 438 of the Industrial Accidents Act did not constitute a bar to civil actions for exemplary damages.²⁴⁹

1.5 Exceptions to the Statutory Bar — Products Liability and Other Employers

There are a number of situations where torts actions may arise outside of the statutory bar to civil action. In the Northwest Territories, for example, the bar is limited to the employer of the injured worker and workers of that employer. Thus, an employee may bring an action against another employer within the jurisdiction for tortious actions that give rise to injuries. However, this is likely to be quite rare, since very few of the hazardous substances used in production processes are manufactured in the Northwest Territories.

In most other jurisdictions, employees are precluded from bringing an action against any Schedule 1 employer for an injury for which benefits are payable under the Workers' Compensation Act. Schedule 1 typically

includes all known manufacturing, construction, and extraction industries within the jurisdiction. However, it is possible an injured employee may have a cause of action that can be exercised against a manufacturer outside the jurisdiction.

In *Meilleur v. U.N.I.-Crete Canada Ltd.*,²⁵⁰ the Ontario Supreme Court allowed an action in negligence by an employee who was employed in Nova Scotia against an Ontario manufacturer and a distributor of the product that caused his injury. The court decided that since the plaintiff was not an employee of a Schedule 1 employer under the Ontario Workers' Compensation Act, his claim against the defendants was not statute barred. Moreover, the court dismissed the defendants' argument that the plaintiff could not succeed in the action because he elected to take benefits under the Nova Scotia workers' compensation legislation. According to the defendant, since under the act the Nova Scotia board became subrogated to all rights arising out of the action against parties other than his employer, the board's subrogated rights are not actionable in another province because the conferring of such rights is *ultra vires* of Nova Scotia legislation as affecting property rights in another province.²⁵¹ The Ontario Supreme Court rejected this argument on the grounds that the employee has the right of action but it is subject to the control of the board.²⁵²

This case lends authority to the proposition that an employee can bring an action in negligence against a manufacturer who is outside of the jurisdiction. However, such suits are highly unlikely for two reasons. In a products liability case the defendant manufacturer is able to raise the defence of contributory negligence. In *Meilleur* the Court found the plaintiff employee to be 75 percent responsible for his own injuries and reduced the damage award accordingly. Also, as is discussed in greater detail below, if the employee elects to receive benefits from the WCB, the board is subrogated to his or her rights and may claim reimbursement for the benefits paid out.

With regard to industries in Ontario that are covered by Schedule 2, the statutory bar applies only to claims against the employer of the injured worker, or an executive officer of the employer. Thus, for example, a Schedule 2 worker may bring a tort action against a Schedule 1 employer, and vice versa. However, since Schedule 2 employers are mainly federal and provincial Crown corporations and departments, it is extremely unlikely that a products liability action would arise.

1.6 Criminal Misconduct in Quebec

The Quebec act provides an exception to the statutory bar to allow a worker to bring an action against an employer (other than the worker's employer) whose industry is subject to the act, where the fault of that employer constitutes an offence under the Civil Code or an indictable offence within the meaning of the Criminal Code. As well, an action may be brought in Quebec against an employer covered by the act, other than the employer of the injured worker, to recover any amount by which the loss exceeds the statutory benefits.

1.7 Derivative Actions

The statutory bar applies to all claims that depend for their validity on the worker having a good cause of action. The bar applies in cases where, under the Family Law Act, family members claim damages resulting from reproductive harms to the worker.²⁵³

2. Where Civil Claims Are Not Barred

Where a civil claim is not barred, the worker may elect in most jurisdictions to pursue a remedy in damages or to claim compensation. If the worker claims compensation, the board is subrogated to the civil right of action, and if the board commences an action pursuant to the right, then, in most jurisdictions, any separate action by the worker is dismissed. The situation in other jurisdictions varies from those with no right of election to those where the worker can claim compensation and pursue a civil action. In Quebec, the worker who claims compensation retains a claim for any additional amount that may be recovered against the person who caused the harm.

Where a worker elects to pursue a civil claim, if, after a trial or a settlement approved in writing by the board, less is collected than the compensation to which the worker is entitled, the worker is entitled to compensation for the difference.

3. Jurisdiction in Relation to the Statutory Bar

Where an action is commenced for personal injury and an issue arises as to whether the action is barred under a workers' compensation act, the boards have exclusive jurisdiction to determine this issue.

Most applications are made in relation to actions for damages for personal injury brought by a worker against an employer or another worker. The board's jurisdiction also applies where the application of the statutory bar arises in other contexts, such as a derivative action by defendants of a worker.²⁵⁴ However, if an action is commenced under s. 61 of the Family Law Act of Ontario by someone who is not a "defendant" within the meaning of that term in the Workers' Compensation Act, the Appeals Tribunal has no jurisdiction to determine whether that claim is barred.²⁵⁵

4. Comparison of Compensation with Damages

It is commonly assumed within the legal profession that workers' compensation benefits amount to less than could be recovered in a civil action, but that is often not so, particularly in cases involving contributory negligence.²⁵⁶ To the extent that workers' compensation systems provide benefits for loss of reproductive capacity, it is likely these benefits are comparable to lump sum awards for loss of reproductive capacity arising out of successful tort actions.²⁵⁷

5. Discussion

The statutory bar to civil actions arising out of workplace injuries is, unlike the situation in the United States,²⁵⁸ both fairly comprehensive and virtually impregnable for all practical purposes because of the boards' right

of subrogation. Since punitive damage awards are quite moderate in Canada, they are often not worth the time and expense of bringing an action. In situations where the statutory bar does not operate, the defence of contributory negligence has operated to reduce the plaintiff's damage award.

G. Civil Actions for Fetal Harm or Injury

1. Competing Goals

The possibility of civil actions for workplace exposures resulting in harm or injury to the fetus serves two functions. First, since workers' compensation legislation does not compensate workers' offspring injured by preconceptive, prenatal, or post-natal exposure to workplace hazards, civil actions for damages may be the only source of compensation for disabled offspring. Second, the widespread belief in fetal hypersusceptibility to hazards in the workplace, coupled with the fear of civil actions for fetal exposure, has led employers to implement policies excluding fertile women from occupations and locations that are potentially hazardous. By contrast, there has been no perception until recently that fetal development may be affected by paternal exposure to hazards, so there has not been a similar exclusion of fertile men. Since (as we discuss in the section of the study on human rights legislation) the vast majority of such policies are implemented in traditionally male-dominated workplaces, women have been, and continue to be, excluded from better-paying male jobs.

Civil actions for fetal injuries are thus a double-edged sword: on one hand, they may provide the only basis for compensating disabled children; on the other, they provide a basis for employers to exclude women from certain types of employment. In this way, the goal of compensation conflicts with that of non-discrimination.

It is important to recognize, however, that this conflict has not been subjected to rigorous scrutiny from a public policy perspective. The possibility of civil actions for fetal damage has been just that — a possibility, rather than a reality. Moreover, the conflict between a discrimination-free workplace and the health and safety of fetuses exists only to the extent that public policy permits exposure levels that are potentially harmful to fetuses. However, to evaluate how the goal of compensating injured offspring and deterring employers from creating work hazards resulting in fetal damage should be balanced against the goal of non-discriminatory employment policies, it is first necessary to examine how likely it is that actions for fetal injury will be successful.

2. Causes of Action

2.1 Wrongful Death

Neither the common law in Canada nor the civil law in Quebec recognizes wrongful death actions. A pregnancy terminated or a fetus stillborn as a result of negligent or intentional action does not provide the basis for an action for damages.

In *Seede v. Camco Inc.*,²⁵⁹ the mother of a fetus aborted as a result of a car accident claimed damages under the Family Law Reform Act on behalf of herself as mother, the father, and other members of the family for loss of the guidance, care, and companionship they might reasonably have expected to receive had the child lived. The defendants argued the action should be dismissed on the ground that there is no cause of action under the Family Law Reform Act because the action on behalf of family members is a derivative action and, inasmuch as an unborn child has no capacity to maintain an action prior to birth, the family members have no such right. The Ontario Supreme Court dismissed the plaintiff's action, stating that:

In Ontario there is no right of action in an unborn child to recover damages nor in favour of an unborn child unless the child is born alive. On the other hand, when the unborn child becomes a living child through birth and suffers damages as a result of prenatal injuries caused by the fault or the negligence of another the cause of action is completed.²⁶⁰

In *Tremblay v. Daigle*,²⁶¹ the Supreme Court of Canada considered the status of the fetus under the Civil Code of Lower Canada. The Court stated that:

The recognition of the foetus' juridical personality has always been ... a "fiction of the civil law" which is utilized in order to protect the future interests of the foetus. This is equally true in Quebec civil law. Articles 608, 771, 838, and 2543 explicitly state that unless the foetus is born alive and viable it will not be granted the rights recognized therein. If the foetus is not born alive and viable then the interests referred to in these articles disappear, as if the foetus did not exist at all. In short, the condition that the foetus be born alive and viable is a "suspensive" condition.²⁶²

The jurisprudence in Canada and Quebec clearly states that a fetus has no rights if it is stillborn. Although reproductive hazards may be linked with a high incidence of miscarriage, these costs of workplace hazards will never be internalized by employers through tort law.

In the United States, the situation with respect to wrongful death actions is somewhat different. Although the right of the fetus to sue for prenatal injury is generally conditioned on its live birth and survival, where the fetus dies before or after birth as a result of injuries sustained *in utero* a wrongful death action may also be brought by the parents in most states.²⁶³ This is because several states have explicitly legislated to this effect. It is always possible, although politically controversial, to grant the fetus legal status through legislation.

2.2 Actions for Fetal Harm or Injury in the Context of Live Births

2.2.1 Civil Code of Quebec

Under the Civil Code of Quebec, actions in negligence are available to a child for injuries caused to it *in utero*. In *Montreal Tramways v. Léveillé*,²⁶⁴ the Supreme Court of Canada interpreted the Civil Code of Quebec to allow an action to be brought by a child who was injured *in utero*.

(*en ventre sa mère*) against a defendant who negligently caused the injury.²⁶⁵

2.2.2 Common Law

The common law also recognizes the right of a child to sue for prenatal injury. In *Duval v. Seguin*,²⁶⁶ one of the plaintiffs successfully sued for damages for injuries sustained while *in utero* from a car accident caused by the defendant's negligence. The Ontario Court of Appeal held that a plaintiff, who at and after birth suffered injuries caused before birth by the defendant's negligence, has a cause of action in respect of those injuries. The court made it clear that although a child has a right to sue for prenatal injury, that right does not vest until the child is born. In effect, the court creates the legal fiction that the defendant's negligence while the plaintiff was *in utero* does not cause damage until the child's birth.

In deciding whether the defendant owed a duty of care to the child *in utero*, the Court in *Duval* stated that:

Procreation is normal and necessary for the preservation of the race. If a driver drives on a highway without due care for other users it is foreseeable that some of the other users of the highway will be pregnant women and that a child *en ventre sa mère* may be injured.²⁶⁷

A child's right of action for prenatal injuries is separate from, and independent of, any right of his or her parents. The effect of this is to preclude parents from waiving any of the child's rights. This means that any waiver signed by the parent on behalf of the child is not enforceable.

In some jurisdictions there is a statutory affirmation of the right of children to sue for prenatal injuries.²⁶⁸ This scheme can be contrasted with the United Kingdom's Congenital Disabilities (Civil Liability) Act, 1976, c. 28, which designates that a mother's voluntary assumption of risk or contractual waiver of liability is binding on her child.

2.3 When the Injury Takes Place

2.3.1 The Concept of Viability

In Canada, unlike the United States,²⁶⁹ there is no requirement that the fetus be viable at the time the injury occurred if the child is to bring an action for prenatal injuries. It simply does not matter at what stage in the fetus's development the injury took place.

2.3.2 Actions for Preconception Exposure

According to Katherine Swinton, "Canadian jurisdictions have not recognized a cause of action for a child damaged by pre-conception injury to its parents."²⁷⁰ By contrast, in the United States, there are a few examples of successful actions for preconception injuries.²⁷¹ However, in Canada, it is likely that it would be possible to bring an action for a preconception tort. In the United Kingdom, the situation is analyzed in the following way: although the cause of action cannot arise until the damage is caused (the child is born), the damaging act may, on principle, take place at any time.²⁷²

2.4 Contributory Negligence on the Part of the Parents

The causes of fetal abnormalities and birth defects are highly speculative in most cases. While there are some studies demonstrating a correlation between workplace exposure to certain substances and these injuries, there are other studies demonstrating a correlation between the conduct of the mother (especially drinking, smoking, and nutritional habits) and similar sorts of injuries. In many cases it will be impossible to isolate the primary causal factors. What this means is that there is an arguable case that parental, typically the mother's, behaviour while the child was *in utero* contributed to, if not caused, the injuries. Moreover, it may be the case that if a parent knowingly exposed the fetus to risks, the parent could be found to be contributorily negligent.

In some jurisdictions, a specific statutory provision enables a child to bring an action against a parent or vice versa.²⁷³ However, although the possibility that a child might bring an action against his or her parent exists, such cases would be extremely rare, as the parent is not likely to have liability insurance to cover the child's damages. It is much more likely the parent would be joined by the defendant as a joint tortfeasor.

2.5 Causation

Although the opportunity exists for children to sue their parents' employers for prenatal injuries, it is difficult to establish the requisite causation to maintain such a suit. Five percent of born children have some congenital abnormality, which is fortunately, in most cases, minor. But only 2 percent of all congenital abnormalities can be attributed to a definite agent a woman was exposed to.²⁷⁴

Therefore, it is difficult to make a causal link between a child's condition and a parent's exposure to a substance at work. Obviously, the parent must know to what substances he or she has been exposed, in what concentration, and for how long.²⁷⁵ Scant and conflicting research relating to the effects of potential reproductive hazards poses additional hurdles for proving causation.

Karen Messing has provided a detailed discussion of the problems of relating exposures to effects when studying reproductive hazards.²⁷⁶ As she notes, effects on a fetus are most serious during the first eight weeks of pregnancy when fetal organs are developing, but most women are not sure of their pregnancy before six weeks at the earliest. Thus, an early miscarriage may not be detected. Similarly, a malformation detected late in pregnancy or after birth may not be traced to workplace exposures in the first few weeks of pregnancy.

As an illustration of the methodological challenges inherent in occupational and health and safety research in general and studies regarding workplace reproductive health in particular, Messing examines the case of VDT exposure. She notes that

there was concern about potential negative effects on pregnancy when four women at the *Toronto Star* who worked with VDTs gave birth to malformed children. Paradoxically, this example could not itself be used to confirm harmful effects of VDTs, but only to call attention to a possibility

that there might be a problem. The occurrence at the *Toronto Star*, technically referred to as a cluster, did not confirm VDT risk because, in the absence of any special exposure to harmful conditions, there is one chance in 25 that any child will be born with a malformation. Similarly, there is a one in 10 chance that any pregnancy will miscarry after the woman becomes aware she is pregnant.²⁷⁷ Therefore, among 5,000 workplaces, where 10 pregnant women work with VDTs, it can be calculated that in two of them, four women or more will give birth to malformed children, and in over 50 of them, four or more women will have miscarriages. Unless a specific risk factor can be identified, measured and related to the effect in a large number of workplaces which all share the same risk factor, it is not possible to prove that the workplace or working conditions are hazardous. The occurrence might have been a statistical accident.²⁷⁸

Moreover, Messing goes on to make the point that

The traditional methods in OHS research rely on the availability of a sufficiently large study group in order to obtain statistically significant results. Results are statistically significant if the researchers have less than one chance in 10 to be wrong if they assert that there is a problem. This can be very frustrating for the worried pregnant woman, who might prefer the burden of proof to be on the other side. For example, it is not easy to find large numbers of pregnant women exposed to similar working conditions at similar stages in their pregnancy, and this has limited the number of connections which can be made conclusively between working conditions and damage to the pregnant woman or the foetus.²⁷⁹

Another problem in trying to demonstrate a causal link between workplace exposure and injury to the fetus and child is that, depending on the dosage, an identified toxin may result in different kinds of illness.²⁸⁰ According to Messing, "foetal damage may vary from miscarriage to neonatal death to malformation, depending on the dosage and time of exposure."²⁸¹

3. Discussion

The difficulty of establishing legal causation provides a partial explanation of why it is that while the right of a child to sue for prenatal injuries exists, no lawsuits have yet been won on behalf of children with occupationally induced birth defects in Canada or the United States. David Kirp has offered the following assessment of the possibility of success for actions against employers for injuries suffered on account of fetal exposure:

The legal risk looks to be more theoretical than real. Very few cases have actually been brought. Thus far, the lone case involving a female employee resulted in a verdict for the company, even though the firm had violated OSHA standards. The only successful lawsuits were filed a decade ago by men whose sexual functioning was impaired by exposure to the pesticide DBCP [dibromochloropropane]. This paucity of litigation may be explained by the fact that, as the Agent Orange litigation showed, it is difficult to demonstrate that on the job exposure, not other

risky behaviours, caused a fetal defect. It is also unlikely that would-be litigants could show that a corporation that followed OSHA standards had been negligent, and such proof would ordinarily be essential for establishing liability.²⁸²

Moreover, given the requirement that injured children be born alive to gain the right to sue and the obstacles of proof, the success of a lawsuit is unlikely.²⁸³

In Canada, there is only one reported instance of an action brought on behalf of a child for prenatal harm caused by *in utero* exposure to toxins in the workplace. A \$7 million lawsuit was launched against English Plastics, a plastics factory in Brampton, Ontario, and several corporations that supplied the factory with plastics, resins, and solvents.

Saskia Post, a former employee, claimed that her baby's deformities resulted from her exposure to toxins in the air, such as styrene and polyvinyl chloride, during early pregnancy. Post worked at the plastics factory for eight days in February 1983 before she found out she was pregnant. She immediately quit her job. Her son Timothy, on whose behalf the lawsuit has been filed, was born in September 1983. Subsequently, it was determined that he suffered a number of conditions: he was mentally retarded and blind, and had poor muscle control and extremely restricted use of his arms and legs. Genetic tests showed that his chromosomes were normal. Furthermore, there was no history of genetic abnormality in the families of the mother and father.

According to the employer, several pregnant women who had healthy children had worked in the plant. Moreover, English Plastics claimed that although it did not specifically warn Post about the hazardous chemicals used in the work processes, material data sheets were posted throughout the premises and the employees were free to look at them. The employer insisted that its ventilation system and engineering controls were up to standard. In response to Post's action, the employer indicated it was considering initiating pre-employment testing.

The legal issues in this case were never resolved because Saskia Post subsequently dropped the lawsuit after Timothy's death in January 1986. His death made pursuing the case unfeasible because a large portion of the damages was for the cost of caring for him.²⁸⁴

Even if Timothy had survived, it would have been extremely difficult to prove both negligence and causation. Evidence relating to the exposure levels and synergistic effects of the substances used in the workplace, and epidemiological and animal studies and medical testimony relating to their impact on fetal development and birth defects, would have to be adduced by the plaintiff. Moreover, the plaintiff would have to establish that such substances at the levels existing in the workplace constituted an unreasonable risk of harm that the posting of material data sheets did not relieve. This is an expensive and time-consuming business, especially since the chances of success are quite small.

H. Conclusion

Tort law and the civil law of delicts are more detrimental than helpful for regulating and minimizing reproductive hazards. Civil liability is a residual mechanism of compensation and deterrence, as most workers are covered by workers' compensation and most workplaces by occupational health and safety standards. Because of the statutory bar to civil actions and the low level of punitive damage awards in Canada, civil actions are simply not an option for workers in most cases. Moreover, for individuals who have no other means of compensation (workers who are outside workers' compensation schemes, partners of workers and their offspring), proof of fault and causation constitute the major barriers to successful civil actions. Employers and manufacturers have greater resources to defend claims than injured plaintiffs have for bringing them. Moreover, with the widespread availability of liability insurance, manufacturers simply do not have an incentive to take preventive actions that are likely to be more costly than insurance.

Because it operates only after an injury has been suffered, litigation is an extremely limited mechanism for dealing with reproductive harms. Moreover, it is an individualized mechanism for dealing with a broader problem. As well, it has perverse effects; rather than shifting the costs of this form of disability from employees and their families to the employer, tort law is invoked to perpetuate women's exclusion from traditionally male jobs.

While the common and civil laws have been unsuccessful in making employers assume the costs associated with reproductive hazards, the potential for liability has been used to perpetuate discriminatory protection policies. Despite the incredible obstacles that militate against the success of a suit for prenatal injuries, employers have rationalized their fetal protection policies on the basis that the threat of civil liability makes the policy a reasonable, *bona fide* occupational qualification (BFOQ) or requirement. Moreover, the concern to protect fetal health has generally, if not exclusively, concentrated on injuries caused through maternal exposure. This concern ignores men's reproductive role and the mounting evidence that workplace exposures of fathers may result in congenital abnormalities in offspring.²⁸⁵

V. Human Rights Legislation

A. Introduction

Initially, human rights legislation was introduced in the 1940s to combat discrimination on the basis of race in access to services and premises ordinarily open to the public. Since then, every Canadian jurisdiction has introduced legislation prohibiting discrimination on a number

of prohibited grounds in a range of situations, including employment.²⁸⁶ While the prohibited grounds of discrimination vary across jurisdictions, most statutes prohibit discrimination on the basis of sex, age, and disability or handicap. Pregnancy is specifically listed as a prohibited ground of discrimination in some jurisdictions.

All jurisdictions recognize, in one way or another, by statute or judicial interpretation, the concept of "*bona fide* occupational qualification," a job requirement that may objectively constitute a preference for or against a particular characteristic protected by a prohibited ground of discrimination. Where the preference is in good faith and relates directly to the actual requirements of the job, there is normally a provision to excuse such a requirement from the operation of the legislation. In some circumstances, depending on either the form of discrimination or the statutory provisions of the particular jurisdiction, this excuse is available only if the employer has fulfilled a duty to accommodate the members of the protected group.

Human rights legislation is available to all employees to challenge discriminatory employment policies and practices. In a unionized setting where the terms and conditions of employment are regulated by a collective agreement, employees may be able to challenge alleged discrimination either through the grievance procedure or by bringing a human rights complaint.²⁸⁷ In a non-unionized setting, human rights legislation is the only avenue of redress available to employees seeking to challenge discriminatory employment practices.²⁸⁸

A variety of human rights issues have been raised in the context of reproductive hazards in the workplace. Most notorious is the long practice of excluding women from predominantly male jobs on the basis of biological differences.²⁸⁹ While the exclusion of women from predominantly male jobs was initially justified on the ground of the vulnerability to injury of women's anatomy and, specifically, their reproductive capacity, women have been slowly breaking barriers and have begun to enter into the better-paying, male-dominated jobs. However, these gains have been met with a new form of resistance, with the biological vulnerability argument now focussing on women's childbearing capacity and, specifically, emphasizing fetal susceptibility to harm resulting from exposure to hazards in the workplace. The fetus is of particular concern to employers because it is seen as "hypersensitive" to potential hazards and is not covered by workers' compensation legislation. Consequently, potential liability for damage caused to children for prenatal exposure is now used as a justification for excluding fertile women from what have been traditionally male-dominated jobs.

Despite estimates that such exclusionary policies are widespread in the United States,²⁹⁰ in Canada there have been but a handful of human rights challenges to exclusionary policies as a form of sex discrimination. This is not surprising, as the labour market is highly segregated on the basis of sex. Women workers are clustered into a number of what have come to be seen as female jobs (e.g., clerical, nursing, retail service), whereas men dominate in the construction, mass production, and resource

extraction sectors of the economy.²⁹¹ Not surprisingly, women on average earn substantially less money than men do.²⁹²

The reasons offered for the sexual division of the labour market are manifold, ranging from women's socialization, childbearing, and child care responsibilities through to systemic sex discrimination.²⁹³ Since, in many instances, exclusionary policies based on fetal susceptibility to workplace hazards are not explicit, it is difficult to isolate this factor as the reason women are not hired to perform certain types of work. Unless such policies are explicit, the possibility of challenging such a policy as a form of sex discrimination is small.

Male workers, on occasion, have challenged exclusionary policies directed to fertile women as a form of sex discrimination on the ground that they have been denied adequate protection on account of their sex. They and their unions have argued that the failure of employers to concern themselves with men's reproductive capacities in reducing potential hazards or implementing protective policies is a form of sex discrimination.

Historically, research has not addressed the effect of work in various situations on men's reproductive capacities.²⁹⁴ Only recently has this research begun to be conducted. Often it is only women who are studied. The families of men are typically ignored, so there is no way of knowing if paternal exposures cause birth defects or miscarriages. This has resulted in a paucity of epidemiological studies and scientific research to back men's claims that exclusionary policies directed to women are a form of sex discrimination. The sex-biased nature of such research is only beginning to be addressed.

It is important to note, moreover, that the approach to protection through the exclusion of women is generally confined to male-dominated jobs.²⁹⁵ When questions have been raised about the effects on pregnancy of anaesthetic gases in operating rooms or organic solvents in dry-cleaning establishments, in jobs traditionally held by women, few, if any, employers have advocated exclusion of women from hospitals or dry cleaners. In fact, in certain instances, employers have proposed that female workers sign a waiver accepting responsibility for any harm to their fetuses during an undeclared period of pregnancy.²⁹⁶

Human rights issues in the context of potential reproductive hazards in the workplace have conventionally been understood as a conflict of interest between women workers who want access to well-paying jobs and those interested in fetal protection.²⁹⁷ From this perspective, employers and regulators are seen as having legitimate interests in protecting fetuses from the conflicting interests of the women who carry them. This ignores the fact that the woman's interest in employment conflicts with fetal prevention only to the extent that workplaces are hazardous to fetuses. There is nothing inevitable about these hazards. The level of hazard to which workers and their offspring are exposed depends on a range of choices, not the least of which is the employer's assessment of the cost of either cleaning up the workplace or implementing policies to accommodate the

susceptibilities of workers. The process of making health and safety decisions is not an exercise in objective fact finding, but rather a value judgment in which economics, politics, and ethics are intimately connected.²⁹⁸

Both male and female workers have an interest in obtaining and retaining employment that does not jeopardize their reproductive health or the health of their offspring. The conflict arising in the workplace context is not between the principle of non-discrimination and health and safety, but rather between the reproductive aspirations of workers and their health and the production decisions of employers. This deeper conflict is ignored because the risks of work are so commonplace that occupational hazard has passed into the language to imply a risk that must be accepted.²⁹⁹

In this section, we examine how human rights legislation has been invoked to challenge exclusionary policies by both women and men. The concepts of *bona fide* occupational qualification and duty to accommodate have been used to balance health and safety concerns raised by workers and employers with the principle of non-discrimination. In addition, we examine whether human rights legislation provides a mechanism enabling workers to accommodate health issues arising out of infertility with continued employment and a secure source of income. As a final matter, we briefly sketch some of the human rights issues surrounding medical monitoring in the workplace.

B. The Elements of a Human Rights Complaint

1. General

Any discussion of human rights legislation is complicated by the fact that there exist 13 such statutes (10 provincial, 1 federal, and 2 territorial) administered by an equal number of commissions. Not only does the scope of the legislation and the standards and procedures provided in them differ slightly from jurisdiction to jurisdiction, so too does the institutional organization of the commissions administering the statutes. A thorough examination of the specifics of the legislation in each jurisdiction is beyond the scope of the present discussion.³⁰⁰ In what follows, only salient differences relating directly to the issues raised in the context of reproductive hazards are discussed.

In most jurisdictions, a human rights complaint can be lodged by the person claiming discrimination, a third party, or the commission itself. When a complaint is made, a human rights officer is assigned to investigate the complaint. In addition to investigating the complaint, the officer will attempt to obtain a settlement satisfactory to the parties and the Human Rights Commission (HRC).

The officer who carries out the investigation has extensive powers of discovery, including the authority to enter a place of employment at reasonable times, to request production of documents, and to make inquiries. If the conciliation stage fails to result in a satisfactory

settlement, an adjudicative stage may follow. In most cases, the commission has exclusive authority to determine whether or not to proceed with the complaint or to dismiss it as unfounded. In making its decision, the commission need not hold a hearing, although it is subject to a duty — whether it be statutory or deriving from the common law — to act fairly. In most jurisdictions, if the commission finds that the complaint is founded, it recommends that the appropriate minister appoint a board of inquiry.

The normal practice is for the minister to appoint a one-person board of inquiry, which is often staffed by a law professor or lawyer. In proceedings before a board of inquiry, the commission itself is a party and has carriage of the complaint. Where there is a complainant, as there is in the vast majority of cases, that person is also a party to the proceedings, as is the employer. In the normal course of events, the commission's lawyer represents both the commission and complainant. The board of inquiry, once constituted, convenes a quasi-judicial hearing to decide the merits of the complaint. Typically, there is a right of appeal from the decision of a board of inquiry to the superior court.

However well human rights legislation may look in theory, in practice the long delays that frequently occur before a complaint gets to the adjudicative level undermine its efficacy. In the federal jurisdiction, Ontario, and Prince Edward Island, for example, delays of two years or more to resolve a case are not uncommon. While some commentators attribute the delay in processing complaints to the commissions' failure to weed out frivolous complaints,³⁰¹ it is also likely that inadequate staffing and resources contribute to the bottleneck.

2. Prohibited Grounds of Discrimination

2.1 Sex

Every jurisdiction across Canada prohibits discrimination on the basis of sex. Employer policies that exclude all women, or women of certain ages, from jobs or locations on the grounds of their health or the health of their fetus constitute a *prima facie* case of sex discrimination.

While the preponderance of human rights decisions and commission practices supports this approach, the Ontario Human Rights Commission initially dismissed a complaint about the exclusion of fertile women from a battery plant in which lead exposure was likely. The grounds for the dismissal was that the exclusion of these women did not constitute sex discrimination because the employer had a legitimate interest in introducing policies to protect a fetus.³⁰² In effect, the commission incorrectly ran together the separate questions of discrimination and *bona fide* occupational qualification.

Since that decision, boards of inquiry and commissions have decided that a policy excluding fertile women on the ground of fetal protection constitutes a *prima facie* case of discrimination. In *Krochak v. Hudson Bay Mining and Smelting*,³⁰³ which dealt with an employment policy prohibiting

the employment of women capable of bearing children in certain smelter positions on the grounds of a perceived risk of injury to a fetus due to lead contaminants, the Canadian Human Rights Tribunal held that

While the result of the policy might be to protect the foetus, it is nevertheless a policy directed towards the employment of female persons either in their totality or in the class defined as female persons capable of child-bearing. In that respect, it marks a difference between men and women.

A policy which is directed at all women capable of bearing children, or all women, is one which focuses on a distinct class of persons ... The Company's policy seems to say to women that if they want to be equal, then they must be the same as men and not have babies. The conclusion can be no different if the policy is directed to all female persons or to all female persons capable of bearing children.

In subsequent cases, both commissions and boards of inquiry have adopted the approach applied in *Krochak*, finding that policies excluding women for the purpose of fetal protection constitute a *prima facie* case of sex discrimination.³⁰⁴ Once the employee demonstrates the *prima facie* case, the employer then has the burden of establishing on a balance of probabilities that the worker's sex constitutes a *bona fide* occupational qualification.

In Nova Scotia and New Brunswick, the employer is prohibited from discriminating against a person, unless and until the employer has obtained an exemption from the commission that the work rule or policy is a *bona fide* occupational qualification. Failure to obtain such an exemption would result in the employer being vulnerable to a discrimination complaint. In New Brunswick, *bona fide* qualification exemptions are not given retrospective effect.

Male workers who allege they are discriminated against on the basis of their sex because they are denied the benefit of protective policies directed only at women would have to establish a *prima facie* case that the employer's policy or actions constitute sex discrimination. The question that arises is whether the failure to exclude men from jobs or facilities from which women are excluded on account of possible injury to their reproductive capacity or offspring constitutes a form of sex discrimination.

To date, there is only one decision under a human rights code dealing with such a complaint. In *Krochak v. Hudson Bay Mining and Smelting Co. Ltd.*, the federal human rights tribunal dismissed the male workers' complaint that they had been discriminated against on account of their sex by the employer's policy to exclude only women from possible lead contamination.³⁰⁵ The complaints were dismissed because the men failed to advance evidence of harm to their reproductive health. This approach is consistent with the arbitrator's decision in *Re General Motors of Canada*,³⁰⁶ where a similar complaint concerning exclusionary policies and lead exposure was also rejected.

The decision in *Krochak* is troubling in a number of respects. While, with the exception of Quebec, none of the human rights legislation in Canada defines “discrimination,” it would appear that *prima facie* proof of differential treatment (unless the differential treatment was frivolous or can be described as *de minimis*) constitutes discrimination, and the onus shifts to the respondent to show justification.³⁰⁷ In *Krochak*, the tribunal required the male complainants to adduce evidence that the differential treatment constituted a disadvantage. Thus, they had to adduce medical and/or scientific evidence that exposure to the levels of lead justifying the exclusion of women would harm their reproductive capacities or offspring. This approach is not consistent with the weight of the jurisprudence on differential treatment as a form of discrimination, nor is it consistent with the policy of placing the burden of proof on the employer to establish that differential policies are warranted. What it suggests is that the tribunal started from the assumption that men are not vulnerable to reproductive harms from lead, whereas women and fetuses are. This is especially disturbing in light of the growing evidence of the potential of reproductive harm to men at low levels of exposure to lead.³⁰⁸

2.2 Pregnancy

In some situations, employers exclude only pregnant women or women who have the capacity to become pregnant. Human rights legislation in the federal jurisdiction, Quebec, Alberta, Ontario, Manitoba, Saskatchewan, and the Yukon explicitly prohibit discrimination on the basis of pregnancy.³⁰⁹ The legislation in Ontario and Manitoba has the most extensive explicit protection against such discrimination since both pregnancy and the possibility of pregnancy are covered.

By contrast, the acts in Newfoundland, Prince Edward Island, Nova Scotia, British Columbia, and the Northwest Territories do not include pregnancy as a prohibited ground of discrimination.³¹⁰ This raises the legal question of whether discrimination against a particular group of women (those who are pregnant or have the capacity to bear children) constitutes discrimination on the basis of sex. Although the Supreme Court of Canada initially held that the different treatment of pregnant women did not constitute a form of sex discrimination,³¹¹ the Court subsequently stated that

discrimination on the basis of pregnancy is a form of sex discrimination because of the basic biological fact that only women have the capacity to become pregnant.³¹²

On the basis of *Brooks v. Canada Safeway Ltd.*, regardless of whether pregnancy is explicitly prohibited by statute, differential treatment on the basis of either pregnancy or the possibility of pregnancy would constitute a *prima facie* case of sex discrimination.³¹³

2.3 Disability and Handicap

Every jurisdiction includes disability (or “handicap”) as a prohibited ground of discrimination. Canada, Quebec, Manitoba, and the Northwest Territories do not define the term “disability.” The other common law provinces provide statutory definitions that are virtually identical. For example, in Saskatchewan, disability means

- (i) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness.³¹⁴

In general, definitional content to the terms “handicap” and “disability” has been provided by the decisions of boards of inquiry. In Ontario, the board of inquiry in *Ouimette v. Lily Cups Ltd.*³¹⁵ interpreted “handicap” quite narrowly. If someone has, or is perceived to have, a condition that meets all the following criteria, they will be considered to have a physical disability within the meaning of the Ontario Human Rights Code:

- i. The condition or perceived condition is permanent, ongoing, or of some persistence; and
- ii. The condition or perceived condition is not commonplace or widely shared; and
- iii. The condition or perceived condition is a substantial or material limit on an individual in carrying out some of life's important functions.

In cases of uncertainty, medical and other evidence should be obtained relating to each of these criteria. In *Lily Cups Ltd.*, the board of inquiry found that an employment policy resulting in the complainant's termination because she was absent from work for two days on account of gastro-enteritis (flu) did not constitute discrimination on the ground of handicap. Specifically, the board was concerned that transitory illnesses, or illnesses that could be suffered by the general population, should not be considered handicaps under the Human Rights Code, the purpose of which is to protect defined groups from discrimination.

By contrast, a board of inquiry in Saskatchewan has adopted a broad approach to the conditions that would constitute disabilities under the Saskatchewan legislation.³¹⁶ In the context of a complaint that the complainant was not hired because of her obesity, the board of inquiry stated that

although every case must be considered with reference to the particular facts being considered in order to determine that the disability is caused by bodily injury, birth defect or illness, the ambit of our Code is not so rigid and narrowly confined as to suggest that the categories of disability are closed.³¹⁷

Regardless of whether boards of inquiry in different jurisdictions adopt a narrow or expansive approach to the definition of disability or handicap, human rights commissions across Canada have indicated their willingness

to treat the failure of employers to accommodate workers who suffer from infertility as a *prima facie* case of discrimination. In some cases, owing to the nature of the treatment, workers need time off to attend at medical facilities. In other cases, they might have to forgo strenuous work activities to increase the likelihood of successful treatment. To establish a case that infertility constitutes a disability for the purpose of human rights legislation, a complainant should be prepared to adduce evidence of medical diagnosis and treatment. Although to date there are no decided cases by human rights boards of inquiry dealing with this issue, arbitrators have found infertility to be a form of disability for the purpose of leave and compensation plans under collective agreements.³¹⁸

3. Direct and Indirect Discrimination

Discrimination can take two forms, direct and indirect (also known as adverse impact or unintentional discrimination). Direct discrimination occurs when a requirement, qualification, or policy is explicitly based on a prohibited ground of discrimination. The exclusion of all women capable of becoming pregnant is an example of direct discrimination.

By contrast, indirect or adverse effect discrimination arises when a seemingly neutral requirement, qualification, or policy has a negative impact on a group of people who can be identified on the basis of a characteristic constituting a prohibited ground of discrimination.

The most common example of indirect discrimination involves complaints laid by practitioners of minority religions. In *Ontario Human Rights Commission and O'Malley v. Simpsons-Sears Limited*,³¹⁹ the Supreme Court of Canada held that an employer's policy requiring its workers to work on Saturday indirectly discriminated against Mrs. O'Malley's right to practise her religion, which involved Saturday observance. According to the Supreme Court of Canada, adverse effect discrimination

arises where an employer for genuine business reasons adopts a rule or standard which is on its face neutral, and which will apply equally to all employees, but which has a discriminatory effect upon a prohibited ground on one employee or a group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other members of the work force ... An employment rule honestly made for sound economic or business reasons, equally applicable to all to whom it is intended to apply, may yet be discriminatory if it affects a person or group of persons differently from others to whom it may apply.³²⁰

A neutral policy equally applied to all members of the workforce may have a discriminatory impact on a disabled employee and thus constitute a *prima facie* case of indirect or adverse impact discrimination. To the extent that infertility is covered within the meaning of disability, employment policies, qualifications, and requirements operating to the detriment of infertile workers who are seeking treatment will constitute a *prima facie* case of discrimination.

There is no specific prohibition of indirect discrimination in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, Saskatchewan, Alberta, British Columbia, and the Northwest Territories. The remaining jurisdictions cover indirect or constructive discrimination in a variety of different ways. Even where there is no specific statutory language explicitly prohibiting indirect discrimination, the courts have read discrimination to include indirect discrimination.³²¹ However, the distinction between direct and indirect discrimination is still important, for, as we shall see, in the absence of a statutory duty to accommodate, the form of discrimination determines whether the employer has to make accommodations for individual employees.

4. Bona Fide Occupational Qualification (BFOQ)

Once the complainant has established a *prima facie* case of indirect or direct discrimination, the burden shifts to the employer to establish that the qualification or requirement is *bona fide*.³²² This is so whether the human rights statute provides a specific *bona fide* occupational requirement or qualification defence.³²³ In every jurisdiction in Canada, however, the human rights legislation provides an exception to discrimination where the discrimination is based on *bona fide* qualifications in relation to sex or ability.

To qualify as a defence to a complaint of discrimination, the employer must prove, on a balance of probabilities, that the BFOQ was:

- (i) imposed honestly, in good faith, and in the sincerely held belief that such limitation is imposed in the interests of the adequate performance of the work involved with all reasonable dispatch, safety and economy, and ...
- (ii) related in an objective sense to the performance of the employment concerned, in that it is reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his fellow employees and the general public.³²⁴

Thus, it is clear that health concerns for employees and others may constitute a BFOQ.³²⁵

Moreover, in *Brossard (Ville) v. Québec (Commission des droits de la personne)*, the Supreme Court of Canada tightened the BFOQ defence by requiring an employer to prove the reasonableness, not only of the objective of the rule, but also of the means chosen to accomplish it.³²⁶ In the *Saskatoon Firefighters* case, the Court went on to elaborate when an employer could say that it was using reasonable means to achieve reasonable ends.³²⁷ In this case, the Court placed a heavy burden on employers seeking relief from their responsibility to conduct individual testing of employees and substituting a general ban. These cases could prove to be particularly important in the context of protective exclusionary policies, since they would require an employer to demonstrate that exclusion of fertile women is the only reasonable means of protecting fetal or reproductive health.

Where an employer seeks to justify a discriminatory policy on the ground that health and safety concerns constitute a BFOQ, it must present evidence persuading a board of inquiry on a balance of probabilities that there is an objective basis for this concern. This will require the employer to adduce scientific evidence and medical testimony in many instances.

The question of whether the employer has established a BFOQ often relates to whether the employer has made reasonable efforts to accommodate the needs of individual or specific groups of employees. For example, in Ontario, direct discrimination on the basis of sex can be a BFOQ only if the Human Rights Commission is "satisfied that the circumstances of the [complainant] cannot be accommodated without undue hardship on the person responsible for accommodating those circumstances."³²⁸ However, in the absence of a statutory duty to accommodate, any such requirement flows from judicial authority. Moreover, despite the practical difficulty of separating the BFOQ from the duty to accommodate, this is precisely what the Supreme Court has done.³²⁹ For this reason, issues relating to accommodation are postponed to the later discussion of the duty to accommodate.

4.1 Exclusionary Policies Directed to Women

In Canada, in the past and still today, employers have excluded³³⁰ fertile women from specific jobs and facilities because of the potential for fetal exposure to reproductive hazards that may result in birth defects. Fetal protection policies raise a number of issues in the context of a BFOQ defence. The first is whether an employer's concern to protect fetal health, for whatever reason, is recognized for the purpose of a BFOQ. The second issue flows from the resolution of the first: if it is legitimate for employers to exclude fertile or pregnant women, what is the evidentiary base they need to establish to justify the exclusion?

Certain toxins have been identified that may result in abnormal fetal development. These can interfere with fetal development in two ways. Mutagens cause genetic damage to the egg or sperm and may result in damage to offspring. They can threaten the reproductive health of either parent. Teratogens poison the growing fetus throughout the pregnancy by interfering with its ability to develop normally. Unlike genetic damage, the developmental effect threatens only the fetus itself, and not the sperm or egg. Teratogens, therefore, threaten reproductive health through the mother alone.³³¹

Although fetal protection policies have been dismissed as an illegitimate basis for excluding women from male-dominated jobs,³³² there is some evidence that even those toxins shown to affect the reproductive process through both sexes may have a significantly greater effect on women. A woman's period of vulnerability is much greater than a man's, and the most vulnerable segment of the reproductive process — when the fetus is undergoing rapid cell proliferation and differentiation — occurs within her. In addition, women may absorb some toxins faster than men

and may absorb and circulate them in the greatest quantities when pregnant. Moreover, Buss notes that reproductive error occurring during fetal development is more likely to lead to tragic results in terms of birth defects than other forms of reproductive error.³³³

The scientific evidence for claiming that potential damage to fetuses through maternal exposure poses a greater risk than via paternal exposure is substantial, but paternal effects have been studied less. However, it is evident that most, if not all, fetal protection policies are directed at women. Moreover, it is also clear that pregnant workers are especially concerned about work-related risks on their health and the health of their offspring.³³⁴

In the context of these considerations, it is important to evaluate when and how human rights boards of inquiry and commissions deal with fetal protection as a BFOQ.

In *Wiens v. Inco Metals Co.*,³³⁵ a case that dealt with a complaint of sex discrimination brought against the employer's policy of refusing to hire women in the pressure carbonyl processing area in one of its nickel refineries, the board of inquiry outlined two approaches that can be taken to the issue of whether fetal protection constitutes a BFOQ. According to the board:

the first, more conservative approach, would say that the employer has a proper concern for the fetus and this will justify a restrictive employment policy. On this first approach, it is not simply a woman's choice to make herself as to whether a fetus will be put at risk by her actions.³³⁶

The board went on to identify the interests competing with the woman's freedom of choice as (a) society's interest in the well-being of every child, and (b) the employer's interest in avoiding possible civil liability to a deformed child born after the exposure of the mother to a toxic substance in her place of employment. By contrast, the second approach to fetal protection would be to say that the question of risk is simply a matter for the mother herself.

The board in *Wiens* indicated its preference for the first, more conservative, approach. Moreover, it would appear that boards and commissions in other jurisdictions have also endorsed this approach.³³⁷

This approach stands in sharp contrast to that adopted by the Supreme Court of the United States in *Johnson Controls*.³³⁸ In that case, the Court had to decide whether an exclusionary policy barring all women capable of bearing children from jobs in a battery plant violated the Civil Rights Act (Title VII), as amended by the Pregnancy Discrimination Act.³³⁹ The majority held that policies that excluded all fertile women for the purpose of fetal protection constituted a form of direct discrimination that could be justified only on the basis of a stringent and narrow BFOQ defence. To constitute a BFOQ the employer would have to demonstrate that the occupational qualification was reasonably necessary to the normal operation of the essence of its business operation — battery making.

According to Blackmun J.,

the unconceived fetuses of Johnson Controls' female employees ... are neither customers nor third parties whose safety is essential to the business of battery manufacturing.³⁴⁰

In rejecting Johnson Controls' "professed moral and ethical concerns about the welfare of the next generation," he held that

decisions about the welfare of future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents.³⁴¹

Moreover, Blackmun J. went on to state, in explicit disagreement with the dissenting decision of White J., that the extra cost of hiring women that may result from successful tort actions for fetal damage "does not provide an affirmative Title VII defense for a discriminatory refusal to hire [women]."³⁴²

Unlike the board of inquiry in *Wiens*, the Supreme Court of the United States in *Johnson Controls* adopted the second approach to the question of whether fetal protection constituted a BFOQ. According to the Court, it is the woman's right, and not the employer's, to balance her interest in employment opportunities against her concern for the well-being of future offspring.

In *Wiens*, the board of inquiry found that although fetal protection could constitute a BFOQ, the employer failed to establish that the exclusion of all women from the pressure carbonyl processing area was reasonable given the slight possibility that harm to the fetus would occur. The evidence failed to establish that there was a significant risk to the fetus from a woman of childbearing age working in the area.³⁴³

However, instead of ending the discussion at this point, the board of inquiry went on to consider whether the employer's duty to accommodate, that is, by employing women of childbearing potential in the plant, would constitute undue hardship for the employer. In taking this step, the board of inquiry distinguished the instant case from *Bhinder v. Canadian National Railway*, in which the Supreme Court of Canada stated that once the respondent established the BFOQ, it was under no duty to accommodate the special needs of an individual employee.³⁴⁴ Despite the attempt to distinguish *Bhinder*, the board of inquiry's consideration of the duty to accommodate in a case of direct discrimination runs contrary to general human rights jurisprudence, which provides that there is no defence to direct discrimination other than a BFOQ.³⁴⁵ The better course for the board would have been to consider whether the means of implementing the policy (in this case the outright ban on women in certain parts of the plant) was reasonable in light of available alternatives.³⁴⁶

To the extent that human rights boards of inquiry and commissions in Canada adopt the approach that accepts fetal protection as a legitimate interest of employers, the evidentiary burden placed on employers seeking to justify exclusionary policies is crucial. The higher the burden, the less likely such policies will be found to constitute a BFOQ.

As noted above, the board of inquiry in *Wiens* decided that the employer failed to establish there was a significant risk to the fetus, which would justify the policy excluding all fertile women as being reasonably necessary to assure the efficient and economical performance of the job without endangering the complainant, her fellow employees, or the general public.³⁴⁷ However, even though the board found the risk of fetal damage insignificant, that the complainant was practising birth control and did not intend to become pregnant was emphasized repeatedly in the decision. Moreover, the board felt it advisable for the employer to implement protective procedures, including warning fertile women of the risk and providing for relocation in the event of pregnancy.

While in some cases the decision to exclude fertile or pregnant women is based on scientific evidence, in other cases it is not. For example, in *Nguyen v. Pacific Building Maintenance Ltd.*,³⁴⁸ the complainant, a cleaner, alleged that her employer had discriminated against her on the basis of sex by laying her off while she was pregnant. Initially, the complainant's supervisor expressed concern about the effects of chemicals in the cleaning solutions on her fetus and asked her to discuss the matter with her physician. She did so and was told she could continue her employment. Her supervisor then wrote directly to her physician stating that he was a "pro-lifer" who feared that a miscarriage or birth defect could result, and that it was not possible to give the complainant lighter work or remove her from chemical contact. Although the complainant's physician wrote to the supervisor reassuring him there was no problem with the complainant's continued employment, she was laid off, allegedly for staffing reasons.

After reviewing the evidence, the board of inquiry found that the plaintiff had established a *prima facie* case of discrimination. Since the employer had not presented any evidence to the contrary, the burden of establishing a BFOQ shifted to the employer. The board held that where there is no clear evidence of potential harm to the fetus or where there are no alternative means of accommodating the employee, an employer's concern for the well-being of an employee's child cannot justify the employee's layoff.³⁴⁹

At present, the approach of boards and commissions to the question of whether a particular exclusionary policy constitutes a BFOQ is deficient in a number of respects. First, it is troubling that employers have been seen in certain cases as having a legitimate interest in excluding women for the purpose of fetal protection since, in the absence of government-imposed exposure standards, they are the ones who establish the risk. This approach does not question whether the levels that are set are acceptable from the point of view of providing equal employment opportunities for men and women. While it is possible that the duty to accommodate will be read broadly to require employers to reduce exposure levels with the potential to cause harm to pregnant women, it is more likely that the duty to accommodate will simply require employers to relocate pregnant women or women who are trying to conceive in a manner that does not impose economic hardship on them.³⁵⁰

Second, by concentrating on the possibility of harm to pregnant women and their fetuses, boards of inquiry and commissions have failed to pay sufficient attention to the possibility of reproductive harm both to men and to fetuses through paternal exposure. One way of ensuring that employers are attentive to these health risks is to require them to prove that (a) the risk to which the policy of excluding women is directed is transmitted only through pregnant women, and (b) they have a factual basis for believing that all or substantially all of the excluded group cannot perform the job without jeopardizing the group's offspring. In other words, the employer would have a positive duty to demonstrate that men and their offspring are not harmed by the risk from which women are excluded. This was the policy of the Equal Employment Opportunity Commission (EEOC) before the U.S. Supreme Court handed down its decision in *Johnson Controls*.³⁵¹

The alternative approach to fetal protection policies — which was sketched in *Wiens* and adopted by the U.S. Supreme Court in *Johnson Controls* — wherein the woman is free to assume the risk of fetal damage, is not without problems. While such an approach would put an end to exclusionary policies discriminating against women, it places the risk on the individual worker without holding the employer accountable for potentially hazardous conditions. Women (and men) want the benefit of equal employment opportunities while simultaneously avoiding risk to their offspring. Thus, it is likely that at least some women will choose not to work in an environment that could result in damage to their offspring. There is nothing in *Johnson Controls* suggesting that the employer is under a duty to minimize this risk either by cleaning up the workplace or by accommodating the needs of workers who, for a temporary period, are especially susceptible to hazards to their offspring.

4.2 Exclusionary Policies Directed to Men

It is well established that workplace exposures can harm men's reproductive capacities.³⁵² Moreover, there is mounting evidence that workplace exposures of fathers may result in congenital abnormalities in offspring.³⁵³ Men, however, are wrongly presumed to be invulnerable to the effects of chemical exposures until conclusive and undeniable evidence of hazards has been amassed. This stands in stark contrast to the assumption that women are vulnerable, an assumption that is extremely difficult to rebut in the context of traditionally male-dominated jobs.

Not only do employers and regulators start from different operating assumptions about the vulnerability of men and women to occupational reproductive hazards, but, once the proof is in that certain substances are in fact harmful, the response is frequently quite different. Once it was established that dibromochloropropane (DBCP) and kepone were hazardous to male reproductive health and the health of their offspring, the substances were banned.³⁵⁴ By contrast, women are excluded from workplaces simply on the suspicion that workplace exposure will result in harm either

to their reproductive capacities or to their offspring. Consequently, there are few instances where men are excluded from workplaces where women are permitted because of a fear for men's reproductive health and safety. In Canada, there are no reported cases of men challenging policies excluding them from the workplace.

There are, however, a few cases where men have brought human rights challenges to employer policies that exclude women on the grounds that they are being exposed to workplace risks on a differential basis because of their sex. As the preceding discussion of these complaints illustrates,³⁵⁵ adjudicators have been loathe to find a *prima facie* case of sex discrimination. Instead, they have imposed an evidentiary burden on men to establish that exposure to the hazard creates a risk to them. Since these cases arise in situations where women are challenging the policies that exclude them, adjudicators have focussed on whether there exists an evidentiary basis justifying a fetal protection policy directed exclusively at women. Men's challenges to sex-based reproductive health policies are not seen as raising an equality issue; rather, they are regarded from the point of view of the right to refuse unsafe work.³⁵⁶

Differential treatment of men and women for the purpose of protecting worker reproductive health and fetuses should be treated as a *prima facie* proof of sex discrimination. Once this is established, the onus should shift to the employer to establish why the different treatment constitutes a BFOQ. To establish a BFOQ, the employer should be required to adduce evidence that only fertile and pregnant women and their fetuses can be harmed by the exposure.

4.3 Infertility as a Disability

Workplace rules of general application relating to staffing, shifts, and leaves may detrimentally impact on infertile workers undergoing fertility treatment. As such, these rules may constitute a form of indirect discrimination on the basis of infertility or handicap. In most instances, employers will be able to establish that such rules constitute a BFOQ, viz., that such rules are enacted in good faith and are reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his or her fellow employees, and the general public. The important question that will then arise is whether employers have a duty to accommodate these workers, and, if so, what actions will the employer be required to take to meet this duty.

5. The Duty to Accommodate

5.1 The Jurisprudence on the Relationship Between BFOQ and the Duty to Accommodate

Over the past decade, the Supreme Court of Canada has developed a conceptual framework for analyzing issues of discrimination by breaking the complaint into discrete elements, such as the form of discrimination, BFOQ, duty to accommodate, and undue hardship. Each element in the

formula has been shaped and reshaped in successive cases to take account of additional assumptions.³⁵⁷ Moreover, this formula has been further complicated by statutory amendments designed to avoid the impact of some of the Court's decisions.

In *O'Malley*, a case involving indirect discrimination, the Supreme Court of Canada held, in the absence of a statutory BFOQ defence, that the employer was required to take positive steps to avoid discriminatory effects, unless making such an "accommodation" would impose an "undue hardship" on the employer.³⁵⁸ By contrast, in *Bhinder*, also a case of indirect discrimination, the Court held that the statutory BFOQ defence displaced any duty on the part of the employer to consider non-discriminatory alternatives for accommodating individual or groups of employees detrimentally affected by the requirement.³⁵⁹ As a result of *Bhinder*, where there was a BFOQ defence but no statutory duty to accommodate, no balancing was required between the legitimate goals of the employer and those of the employee.

Bhinder has been subjected to a great deal of criticism³⁶⁰ and has been legislatively pre-empted in some jurisdictions.³⁶¹ Recently, it was over-ruled by the Supreme Court of Canada in *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*,³⁶² where the Court held that, in the case of indirect discrimination, an employer is required to reasonably accommodate employees up to the point of undue hardship.

Although the majority of the Court in *Central Alberta Dairy Pool* stated it was not providing a comprehensive statement or exhaustive list of what constitutes undue hardship, the Court provided a list of factors that may be relevant to such an appraisal:

They might include financial cost, disruption of a collective agreement, problems of morale of other employees, interchangeability of work force and facilities. The size of the employer's operation may influence the assessment of whether a given financial cost is undue or the ease with which the work force and facilities can be adapted to the circumstances. Where safety is at issue both the magnitude of the risk and the identity of those who bear it are relevant considerations.³⁶³

The Court noted, moreover, that the results of balancing these factors against the right of the employee to freedom from discrimination will vary from case to case.

Despite positive elements in the decision, *Central Alberta Dairy Pool* is not without its problems — mostly because it emphasizes the difference between direct and indirect discrimination. The majority of the Court held that the duty to accommodate displaces the BFOQ defence, but only in cases of indirect discrimination. In cases of direct discrimination, an employer would not be under a duty to accommodate, but instead would have to establish that the rule is a BFOQ.³⁶⁴ If the BFOQ defence is stringently applied such that the employer is required to prove the reasonableness of both the objective of the discriminatory policy and the means of implementing it,³⁶⁵ there may be little practical difference between

what is required of employers in cases of direct and indirect discrimination. In fact, the Court stated in *Central Alberta Dairy Pool* that *Brossard* stands for the proposition that if a reasonable alternative rule exists to the one the employer has implemented that burdens members of a group, the employer's rule will not be *bona fide*.

Since fetal protection and other forms of exclusionary policies, in the vast majority of cases, are directed at fertile or pregnant women, they constitute a form of direct discrimination. In the absence of a statutory requirement to the contrary, there is no duty on the employer to accommodate female or pregnant employees up to the point of undue hardship. However, as part of a BFOQ defence, the employer must demonstrate that there are no reasonable alternatives, short of discrimination, that would achieve the employer's reasonable objective of protecting reproductive and fetal health. A consideration of such alternatives would include: notification to employees of the suspected hazard; relocation on notification of pregnancy; paid or unpaid leave (depending on the circumstances); and monitoring.³⁶⁶ Moreover, an adjudicator might conclude that, in certain circumstances, protective devices, hygiene protocols, and engineering controls are reasonable alternatives. However, the further the alternative is seen as departing from individual accommodation and involving the reorganization of production, the more unlikely it is that adjudicators will consider such an alternative to be reasonable. The outright ban of suspected hazards or an order to lower the level of exposure will likely be seen as too far a departure from the realm of human rights into the realm of health and safety.

By contrast, work rules or policies detrimentally impacting on infertile workers undergoing fertility treatment would constitute a form of indirect discrimination on the basis of disability. In such circumstances, employers would be obligated to accommodate these workers to the point of undue hardship. Flexible hours, unpaid leave or paid disability leave, and job relocation would typically constitute reasonable accommodation unless the employer could demonstrate that such accommodations would either greatly disrupt an existing collective agreement or impose onerous financial burdens.

5.1.1 Statutory Provisions

Only the human rights codes in Ontario and Manitoba contain a specific duty to provide accommodation with respect to sex discrimination. Under s. 23(2) of the Ontario Human Rights Code, the commission will not find an occupational qualification reasonable and *bona fide* unless the needs of the person cannot be accommodated without undue hardship. The determination of what constitutes undue hardship for the employer involves a consideration of "the cost, outside sources of funding, if any, and health and safety requirements, if any." In Manitoba, the definition of discrimination in s. 9(1) includes the "failure to make reasonable accommodation for the special needs of an individual or group, if those special

needs are based upon any characteristic referred to in subsection 2 [which includes sex and pregnancy].” Unlike Ontario, there is no specific undue hardship defence in the Manitoba code.

Both Ontario and the Yukon provide for a specific duty to accommodate disabled or handicapped employees. The Ontario code provides that:

s. 16(1) A right of a person under this Act is not infringed for the reason only that the person is incapable of performing or fulfilling the essential duties or requirements attending the exercise of the right because of handicap.

(a) The Commission ... shall not find a person incapable unless it is satisfied that the needs of the person cannot be accommodated without undue hardship on the person responsible for accommodating those needs, considering the cost, outside sources of funding, if any, and health and safety requirements, if any.

The Ontario commission has introduced guidelines on reasonable accommodation and undue hardship in disability cases³⁶⁷ to clarify that the scope of the obligation encompasses the concept of dignity. According to the guidelines, accommodation does not mean all or nothing — it is a matter of degree. The commission notes that, in determining undue hardship, there is no provision for “business inconvenience” or “undue interference” with the enterprise responsible for accommodation. If the employer is alleging cost factors in determining undue hardship, they must be quantifiable, shown to be related to the accommodation, and so substantial that they would alter the essential nature of the enterprise or so significant that they would affect its viability.³⁶⁸ In establishing that health concerns constitute undue hardship, the employer has a similar heavy burden.

Section 7 of the Yukon Human Rights Act establishes a duty to make reasonable provisions for the special needs of others where those special needs arise from physical disability. This duty does not exist where the making of the provisions would result in undue hardship. Undue hardship shall, according to s. 7(2), “be determined by balancing the advantages and disadvantages of the provisions by reference to factors such as (i) safety, (ii) disruption to the public, (iii) effect on contractual obligations, (iv) financial cost, [and] (v) business efficiency.”

The statutory provisions for determining undue hardship are strikingly similar to those listed in *Central Alberta Dairy Pool*. Basically, the concept of reasonable accommodation short of undue hardship requires the adjudicator to balance the principle of non-discrimination against both cost and health and safety factors. Where any particular line will be drawn will depend as much on the characteristics of the employer (e.g., size and ability to absorb additional costs) as on the needs of the complainant.

To date, only Ontario has specifically dealt with the duty of reasonable accommodation as it relates to reproductive health and fetal protection policies. Although the board of inquiry in *Wiens* found that the likelihood

of harm to the fetus was too remote to justify the policy excluding women from parts of the employer's facility, it considered the question of reasonable accommodation. The board suggested that accommodative measures resulting in a violation of occupational health and safety legislation might amount to undue hardship, but that a potential increase in workers' compensation or other premiums would not.³⁶⁹

The board also stated that the employer could accommodate the risk of fetal damage and subsequent tort liability by: providing full information to female employees; recommending the use of a reliable method of birth control; advising against becoming pregnant while employed in the potentially hazardous position; and providing the option to transfer to a hazard-free area of the workplace upon intending to become pregnant, without disadvantage in terms of earnings, benefits, and seniority. It is important to note, however, that in this case the employer was quite willing to accommodate female employees by making alternative work available when an employee indicated she intended to become pregnant. Whether the board would have ordered the employer to accommodate pregnant employees by offering them relocation with no financial burden where the employer opposed such an accommodation is another matter. In this case, owing to the size of the employer's operations, it is likely that this form of accommodation would not amount to undue hardship.

The second case in which an Ontario board of inquiry has considered the duty to accommodate in the context of reproductive hazards is *Heincke v. Brownell*.³⁷⁰ The complainant, who was pregnant and feared the fumes from her work were hazardous to her fetus, alleged that her employer's refusal to transfer her from her spray-painting job to a job in the plant's packing area, where the risk of harm to her fetus was minimal, constituted sex discrimination. On learning of her pregnancy and being advised by her doctor not to continue to work in an area exposed to paint fumes, the complainant requested a transfer to the packing area. Initially, the employer acceded to her request for a transfer. After three weeks, however, the employer placed her on unpaid leave of absence. The complainant then obtained a second letter from her doctor indicating that her transfer to the packing area was a sufficient precaution. The employer responded by demanding that her doctor actually visit the plant and certify that there was no danger to her fetus from fumes in the packing area. Although the complainant's union filed a grievance challenging the refusal to grant a transfer, it was never submitted to arbitration, as the union decided to pursue the matter through negotiations.³⁷¹

Investigations by Ministry of Labour occupational health personnel subsequent to the filing of the complaint indicated that the level of hazardous fumes in the packing area was minimal. Although the ministry experts testified that the level of hazardous substances in the spray-painting room did not constitute an unacceptable risk for pregnant workers, they were careful to avoid any suggestion that the advice of the complainant's doctor was wrong. However, the board of inquiry accepted

the evidence of an independent expert in toxicology that the fumes in the spray-painting room represented a real and unacceptable risk for a pregnant worker and her fetus, especially in the early stages of pregnancy.

The board held that there was adverse effect discrimination on the basis of sex because the employer insisted that all spray-painters, even those who were pregnant, must continue to do the spray painting job or take an unpaid leave of absence, even if other work was available. Moreover, the board noted that the employer's refusal to transfer the complainant was not related to a shortage of work, financial cost, disruption to the collective agreement then in effect, or problems relating to the interchangeability of the workforce. Rather, its decision related to the restrictions imposed by the complainant's doctor and concerns about the air quality in the packing area.

The board further held that the employer had failed to establish that continued employment in the packing area presented a risk to either the complainant or her fetus and, thus, that it did not meet its duty to accommodate the complainant. Not only was there no objective basis for the employer's concern about potential harm from exposure to fumes in the packing area, but any such concerns could have been accommodated by providing the complainant with a respirator. The board awarded the complainant \$3 000 for general damages in addition to her lost wages.

The Ontario Divisional Court unanimously upheld the decision of the board of inquiry in *Emrick Plastics v. Ontario (Human Rights Commission)*.³⁷² The court reaffirmed the board of inquiry's finding that there was no objective basis for the employer's concern about harm to the complainant's fetus from the air in the packing room. Moreover, the court emphasized that it was unreasonable for the employer to insist that the complainant's physician provide it with what would amount to a legal indemnification against potential lawsuits. According to the court:

That goes beyond true concern for the employee's health and the health of her unborn child. It seeks to conscript her physician into service as her employer's insurer. It detracts unreasonably from a pregnant woman's freedom to make her own reasonably informed employment and medical choices.³⁷³

However, the court was very careful to state that since there was no objective finding of potential harm to the fetus, it did not have to consider the views expressed by Blackmun J. in *Johnson Controls* nor engage in the balancing referred to in the *dicta* in *Wiens*. What the court would have done in the event of a finding of potential harm to the fetus and the related issue of the employer's possible liability is an open question.

Whether employers will be required to accommodate infertile employees undergoing fertility treatment has not yet been addressed by any human rights commissions or boards of inquiry. However, commissions have indicated a willingness to consider the failure of an employer to accommodate the needs of such employees as a form of indirect discrimi-

nation. Since fertility treatments typically last for only short periods of time, flexible work arrangements or paid leaves would not likely constitute undue hardship, except for very small employers. In these situations, adjudicators will be confronted with deciding the question of who should bear the burden of the disability — workers or their employers. While there is no human rights case law on this issue, there are cases where grievance arbitrators have decided that women who need time off work to undergo *in vitro* fertilization procedures are entitled to disability and illness benefits under their collective agreements.³⁷⁴

5.2 Union Liability for Failure to Accommodate

One of the factors to be considered in determining whether an employer has a duty to accommodate is whether the accommodation would disrupt existing collective agreements. In *Gohm v. Domtar Inc.*, an Ontario board of inquiry held that both the union and the employer had violated the code's prohibition of religious discrimination because they failed to accommodate the complainant's religious beliefs.³⁷⁵ In that case, the collective agreement did not provide an automatic defence to a claim that accommodation could not be provided. However, it should be noted that in this case the requested departure from the terms of the collective agreement would not have impacted detrimentally on other employees. But where, for example, the transfer of workers required to accommodate health and safety concerns for themselves, their fetuses, or fertility treatment infringes the job-posting rights of other employees, it is conceivable that modification to the collective agreement could be considered undue hardship.³⁷⁶ However, since such transfers are most likely temporary, the case for undue hardship is weak.

C. Human Rights Commission — Policy

In some jurisdictions, human rights commissions have developed guidelines, the purpose of which is to define the direction and approach for advising potential complainants about the commission's jurisdiction and to prepare recommendations for commission decisions about whether to proceed with or dismiss complaints.

In 1987, the Canadian Human Rights Commission developed a policy on pregnancy and childbirth discrimination. According to the policy, pregnancy or childbirth is widely construed to include conception, the health and safety of the expectant mother and the fetus, complications of pregnancy and childbirth, and the possibility of pregnancy. With respect to health and safety hazards, the policy states that:

If a health and safety hazard affects both sexes, a policy directed at women only will be considered discriminatory. If a hazard affects only pregnant women, a policy directed at all women of childbearing years, but not pregnant, will be considered discriminatory.

Moreover, to be considered non-discriminatory, an employer's policy must meet the criteria set out in the Bona Fide Occupational Requirements/Bona Fide Justifications policies. The policies are designed to encourage employers "to take the only step ultimately able to deal with the problem" of workplace reproductive hazards, which is "the elimination of or drastic reduction in exposure to hazards to health and safety."³⁷⁷ In effect, they place the burden on the employer to demonstrate why fertile and/or pregnant women need to be singled out for protective treatment and to adopt methods, short of exclusion, to accommodate health and safety concerns. In those instances where it can be established that pregnant workers and their fetuses are more susceptible to hazards than other workers, temporary reassignment should be made available where possible. Since the guidelines were adopted by the commission in 1987, there have been no tribunal decisions on issues regarding reproductive health. This suggests that a pro-active policy approach is preferable to case-by-case adjudication for dealing with the discriminatory effects of exclusionary policies.

As previously noted, the Ontario Human Rights Commission has issued guidelines about what constitutes a disability or handicap for the purpose of human rights legislation.³⁷⁸ The guideline sets out detailed considerations regarding reasonable accommodation and the related issue of undue hardship.

D. Medical Monitoring

Medical monitoring, broadly understood as involving any form of medical examination (including questionnaires) offered or required in connection with employment, raises a number of human rights issues.³⁷⁹ In particular, the three issues of concern are: (i) the integrity of the person, (ii) the equality of the worker's opportunity without being hindered by discrimination, and (iii) the right to privacy. While medical monitoring has been justified as a method of preventing occupational disease and enhancing occupational health and safety, these claims have been disputed.³⁸⁰ While in some situations medical monitoring has been used in conjunction with reproductive hazard policies designed to minimize the risk and enhance equality,³⁸¹ there is a legitimate concern that they result in the erosion of basic human rights.

Intrusive testing devices — such as blood and urine testing to determine whether exposure levels have been exceeded and questionnaires seeking to isolate lifestyle decisions from occupational factors in determining risk — compromise personal integrity and privacy. Moreover, the identification of "susceptible" workers may result in discriminatory treatment. While it might be possible to justify medical monitoring in certain circumstances, it should be up to the advocates of medical monitoring to demonstrate the scientific validity of what they propose.³⁸² Thus, legislative standards that place the burden on employers who seek

to implement medical monitoring for health and safety reasons should be introduced.

E. Conclusion

Human rights legislation is the primary institutional mechanism for redressing unequal or discriminatory access to and treatment in the workplace. In Canada, such legislation is complaint-driven. As such, a prospective employee must have reason to believe that he or, much more typically, she is being discriminated against on a prohibited ground. Because of the sex-segregated nature of the Canadian labour market, it will often be difficult for a woman to discover whether or not she is being denied access to employment as a result of a policy excluding fertile women to protect fetal health. Even when a woman has access to sufficient information supporting a *prima facie* case of sex discrimination, she will often have to wait several years before the complaint is adjudicated. In this way, equality becomes an afterthought.

The few human rights cases decided in Canada suggest the prevailing view is that fetuses are hypersusceptible to workplace hazards, especially the hazards that arise in male-dominated workplaces. Reproductive hazards occurring in female-dominated workplaces, such as hospitals and offices, tend to be either minimized or ignored. As well, the potential harm to male reproduction and to fetuses through paternal exposure also tends to be downplayed. The perception of the supervulnerability of fetuses to workplace hazards is extremely controversial. In fact, some commentators have claimed that "almost all conditions which are dangerous for pregnant women also pose a risk for male reproductive or general health as well, and many traditional jobs involve risks for the fetus."³⁸³

There has been little discussion of whether medical treatment that temporarily interferes with some aspects of an employee's job performance should be accommodated by employers. To the extent that we recognize the importance of reproduction personally and socially and require employers to accommodate the special needs of employees with functional impairments that interfere with aspects of their work performance, the needs of infertile employees should be accommodated.

The related concepts of BFOQ and reasonable accommodation are the means by which human rights adjudicators balance health and safety concerns with the principle of equality or non-discrimination. The problem, however, is that although the Supreme Court of Canada has articulated a variety of tests and approaches to these related issues, they are extremely flexible and depend, to a large extent, on the competence and views of the decision maker. Moreover, it is unclear whether the requirement on the employer to establish a BFOQ in a case of direct discrimination is equivalent to the duty to accommodate up to undue hardship in cases involving indirect discrimination. This doctrinal confusion fails to provide first-level adjudicators with sufficient guidance to ensure consistency in approach and result.

Moreover, because adjudicators are confronted with individual situations involving either an impugned exclusionary policy or a request for accommodation on the grounds of reproductive health, they can neither foresee nor develop the full policy implications of a particular decision with respect to the inter-related concerns of equality in employment and reproductive health. Health and safety and human rights need not be contradictory. As Rioux has stated:

Safety and health can be safeguarded by modifying the **workplace** and/or modifying the **workforce**. Although these approaches are neither exclusive or incompatible as attempts to deal with sources of risk, a modification of the **workforce** runs the risk of shifting the burden of health and safety protection to the shoulders of those most-at-risk or those with special sensitivities. Clear evidence is therefore necessary to ensure that equal opportunities are not unjustifiably denied to persons who are perceived as the sources of reduced safety in the workplace.³⁸⁴

The problem is that human rights boards of inquiry, which are appointed to deal with individual complaints, simply do not have the institutional capacity to assess the scientific and medical evidence of risk against the financial costs of protection and accommodation. The implementation by commissions of policies that establish a consistent approach to reproductive health concerns in a non-discriminatory manner is a step in the right direction; it simply does not go far enough.

What is needed is a generic reproductive hazard standard containing the following provisions:

- Evidence establishing a *prima facie* case that workers of either sex are at risk, or that a fetus exposed via the mother or father is also at risk, should trigger the assumption that all workers are at risk until proven otherwise.
- The approach of controlling reproductive hazards should be similar to that for other hazards; that is, first by eliminating the hazard; second, by using engineering and work practice controls — not discriminatory personnel policies.
- Voluntary light duty and medical removal protection with retention of pay, seniority, and benefits should be guaranteed to all current potential parents and pregnant workers. Medical removal policies should be written so as to protect the most vulnerable employees, pregnant or otherwise, from chemical or physical stressors.³⁸⁵

Such an approach would ensure that the health and safety of adult workers is regarded as being as important as the health and safety of fetuses. Moreover, it would ensure consistency of application, avoid the need for lengthy and expensive litigation, and address the reproductive needs of all workers.

VI. Labour and Employment Law

A. Overview

There are three legal mechanisms that regulate the terms and conditions of employment — the common law contract of employment, employment standards, and collective bargaining legislation. These latter two forms of regulation were introduced to redress the fact that the common law fails to either recognize or redress the inequality of bargaining power between workers and employers.

In Canada, collective bargaining is the preferred public policy response to the inequality in bargaining power. Despite this, the unionized portion of the labour force has never climbed above 40 percent of the non-agricultural workforce and has hovered in the high 30s throughout the 1980s.³⁸⁶ Historically, employment standards legislation has played an adjunct role to collective bargaining; it continues to be confined to providing minimal terms of employment for workers (most of whom are women) located in the secondary labour market, which is characterized by low rates of unionization, poor working conditions, and non-standard jobs.

Unionization enhances the bargaining power of workers. Not only do unions improve workers' terms and conditions of employment, they provide the support that is necessary if workers are to exercise their statutory rights. Workers who lack union representation may be less likely to report or take action to reduce health and safety hazards for fear of retaliation by the employer. Non-unionized workers are therefore more likely to accept conditions that endanger their health and safety. Women disproportionately lack unionization and its benefits.³⁸⁷

The growth in non-standard employment is undermining the terms and conditions of employment of workers in Canada. Between 1981 and 1986 the four main forms of non-standard employment — part-time work, short-time work, own-account self-employment, and temporary help agency work — accounted for about half of all new jobs and now represent about 30 percent of total employment.³⁸⁸ Women are disproportionately situated in these non-standard jobs and are therefore much more likely to be non-unionized, low paid, employed in small workplaces, and without employment-related benefits. These workers are therefore more vulnerable to health and safety risks at work.

For the most part, even unionized workers have been unable to bargain for health and safety provisions that are significantly better than the rights provided by statute. For example, just under half of the collective agreements in Ontario registered with the Ministry of Labour as of February 1992 contained a right to refuse unsafe work. Out of 3 384 collective agreements, only 80 (6.18 percent) specifically provided pregnant employees with a right to refuse to work on a VDT while pregnant, despite the fact that many unions have expressed concern about the possible harm to the fetus.³⁸⁹

In this section, we review those aspects of employment law touching on the issues concerning substances or agents that may be reproductive hazards in the workplace.

B. The Common Law Duty to Provide Safe Work

Historically, common law has been an inadequate mechanism for protecting the health and safety of workers.³⁹⁰ The contract of employment was interpreted as including a term implied by law that employees voluntarily agree to accept the risk of injury due to risks present in the workplace. This was known as the doctrine of voluntary assumption of risk. One of the risks presumptively assumed by workers was the risk of injury due to the acts of co-workers. This was the common employment doctrine. Finally, at common law, contributory negligence by the worker provided the employer with a full defence. There was no attribution of liability to employers.³⁹¹ The legislatures and courts eventually mitigated the harshness of these doctrines by holding that an employer had a positive legal duty to all its employees to provide a safe system of work. This included an obligation to provide: (1) competent workers; (2) safe tools, machinery, and equipment; (3) a safe place of work and safe access to that place of work; and (4) a safe system of working.³⁹² Since these are the employer's personal responsibilities, they cannot be delegated to competent managers or an independent contractor. Also, the legal presumption that a worker voluntarily assumed the risk of injury, including the risk of injury from the negligence of co-workers, was abolished and statutes were passed allowing for attribution of fault where there was contributory negligence on the part of the plaintiff.³⁹³

At common law, the worker has a right to refuse unsafe work. However, since the exercise of this right would likely result in dismissal (the only remedy being an action for damages), it was not used very often. Thus, the common law has gradually been superseded by various legislative duties spelling out the employer's obligation to provide a safe workplace and statutory rights protecting workers who lawfully exercise their right to refuse.

C. Employment Standards Legislation

1. *Pregnancy Leave*

Each jurisdiction in Canada provides for maternity leave in its employment standards legislation to give job security to women who take time off work to have a child. The legislation in the different jurisdictions varies with respect to the minimum requirements for obtaining leave and the length of and entitlement to benefits during leave.³⁹⁴

The length of pregnancy leave varies across Canada from 17 to 20 weeks. Most jurisdictions regulate the amount of leave that can be taken by the employee prior to the estimated date of delivery, and some

provide for an extension of the maternity leave for a specified time. All jurisdictions require the employer to reinstate the employee to the position she held prior to the leave or to an alternative position of a comparable nature.

Some jurisdictions provide that an employer may require an employee to commence a leave of absence where the employee cannot perform her job duties because of the pregnancy.³⁹⁵ Moreover, the employer can require the employee to continue her leave of absence until she provides a certificate from a medical practitioner stating she is able to perform her duties. The effect of this provision is to absolve the employer of any responsibility to accommodate the needs of pregnant employees. Instead of relocating the employee or modifying her job, the employer can simply force her to take her pregnancy leave early.

The Labour Standards Act of Quebec provides that the government may, by regulation, extend the length of a pregnancy leave where, among other things, there is a risk of miscarriage or a risk to the health of the mother or the unborn child.³⁹⁶ This provision is consistent with the right of temporary removal with pay and benefits provided under the Quebec occupational health and safety legislation. However, the Labour Standards Act also provides that an employer may require a pregnant employee who is still at work in the sixth week preceding the expected date of delivery to produce a medical certificate attesting that she is fit to work. Failure to produce such a certificate within eight days will entitle an employer to require an employee to take her pregnancy leave immediately.³⁹⁷

Provisions that entitle an employer to require a pregnant employee to take her pregnancy leave when the employer decides that she cannot perform her job responsibilities are designed to ensure productivity, rather than to enhance the safety of pregnant workers and their offspring. A pregnant employee may be disinclined to begin her leave much before the expected date of delivery since it will shorten the amount of time she can stay home with her child.

The federal government has announced its intention to introduce an amendment to the labour standard provisions of the Canada Labour Code that would give an employee a right to reassignment or job modification and associated salary continuation during pregnancy and the nursing period. This provision would take precedence over the existing employer right to require an employee to take a leave of absence during pregnancy. If reassignment or job modification is not reasonably practicable, or if the employee cannot perform any work, the existing employer right to require the employee to take unpaid leave would be twinned with a new employee right to take unpaid maternity-related leave.

The federal proposal falls well short of the right to reassignment or compensation in lieu for pregnant or breast-feeding workers provided in the Quebec occupational health and safety act. In Quebec, the worker receives full compensation through the workers' compensation system, rather than the lesser amount available through the unemployment insurance act.

Moreover, it is important not to confuse pregnancy leave, which is made available for women to recover from delivery and spend time with their infants, and the right to relocation or compensation in lieu thereof, which is designed to protect maternal and fetal health and safety.

D. Collective Bargaining Arbitration

A collective agreement can be defined as a written agreement between an employer and the bargaining representative of the employee with respect to the terms and conditions of employment. The subject matter of a typical collective agreement may be divided into six categories: general terms, security clauses, settlement of disputes, wages and hours, conditions of work, and fringe benefits. At common law, it is not enforceable as a civil contract, but statutory provisions now ensure the collective agreement is binding on the union, on the employees under the agreement, and on the employer.

The grievance procedure involves discussions between the parties with a view toward negotiating a settlement of disputes arising during the term of a collective agreement. The process is triggered by one of the parties who perceives that it is aggrieved in a specific factual dispute. Typically, there are a number of informal stages through which the grievance must proceed.

Arbitration is an adjudicative method of settling industrial disputes arising out of the application of terms of the collective agreement. A third party is chosen to decide the merits and facts of a particular case. When the informal procedures fail to yield a settlement, the arbitrator makes an authoritative decision and award. The arbitrator's role is to adjudicate the dispute based on the evidence and arguments at the hearing.

Except in a narrow range of cases, which include health and safety, the rule is that an employee must obey an order and then initiate a grievance if she or he feels the order violates the collective agreement. The "work now, grieve later" principle does not apply, however, when an employee refuses an order on the grounds that it poses a danger to her or his health and safety. If the employer disciplines a worker for refusing to obey an order and the employee challenges the discipline, the employer must prove, on a balance of probabilities, that it had just cause to discipline. In other cases, the party alleging a violation of the collective agreement has the onus of establishing the violation. Although grievance arbitration is justified as an informal mechanism for resolving collective agreement disputes, it often takes months for a grievance to get to arbitration. As well, there is often a significant delay between the hearing and the issuance of the award. During this entire process, the employee must abide by the order of the employer or suffer the consequence of discipline.

1. No-Discrimination Clauses

An increasing proportion of collective agreements contain "no-discrimination" clauses prohibiting discrimination on the basis of enumerated grounds and setting out the remedies available to an arbitrator

in the event that discrimination is established. Arbitrators will construe a no-discrimination clause in a collective agreement to accord with the relevant human rights code, such that a BFOQ exception will be implied.³⁹⁸ This exception has tended to benefit employers by allowing them to discriminate against employees so long as they can show a business (as opposed to an invidious) reason for the discrimination they practise. Moreover, in the absence of a no-discrimination clause, arbitrators will interpret the collective agreement so as to adhere to the requirements of statutory standards, including human rights legislation.³⁹⁹ Thus, when adjudicating a grievance in which sex discrimination is alleged, arbitrators may refer to the relevant human rights legislation.⁴⁰⁰ But despite urgings to the contrary,⁴⁰¹ this does not mean that arbitrators have the right to apply human rights legislation in arbitral proceedings in order to remedy discrimination. In the absence of clear legislative authorization, such as exists in Nova Scotia and British Columbia,⁴⁰² the remedies available for discrimination must flow from the collective agreement and not from human rights legislation.⁴⁰³

Different treatment of men and women workers on the basis of sex constitutes a *prima facie* violation of the employer's duty to exercise its prerogatives fairly. Once the grievor establishes a *prima facie* case of sex discrimination, the onus shifts to the employer to establish that sex is a BFOQ.

Sex discrimination allegations may arise when employers institutionalize rules purporting to protect fetuses from exposure to workplace hazards. It is argued that such rules discriminate against women of childbearing age and pregnant women by excluding them from certain types of jobs. At least one arbitrator has upheld a company rule excluding fertile women from jobs that posed a potential risk to a fetus, on the basis that employers have a *bona fide* interest in protecting fetuses from hazards.⁴⁰⁴ In *Re General Motors of Canada*, the arbitrator dismissed the union's grievance that the company's reproductive hazards policy discriminated against men as it applied only to fertile women. The arbitrator acknowledged that the union had established that there was some cause for concern that fertile men who were exposed to lead might be impaired; however, identifying his "reluctance as a layman to make definitive findings in an area where technical skills are vital" as his reason, he upheld a reproductive hazards policy that excluded fertile women but permitted fertile men to work in an area where exposure to toxic levels of lead was likely.⁴⁰⁵

2. Duty to Accommodate

The problem of excluding women workers from non-traditional jobs is just one aspect of the problem of reproductive hazards in the workplace; the flip side concerns the desire of women workers for the right to transfer out of jobs they believe pose a threat to their present or future children.⁴⁰⁶ Arbitral jurisprudence permits a pregnant woman to refuse to work on a VDT, but it does not provide the woman with a right to transfer to another job or require the employer to make reasonable accommodations for the

pregnant employee in the absence of specific wording in the collective agreement.⁴⁰⁷

Some unionized employees have obtained rights to reassignment during pregnancy through collective bargaining. According to Swinton, the advantage of negotiated provisions is their flexibility: "the parties can tailor a clause which meets the special hazards of their workplace and meshes with existing seniority systems."⁴⁰⁸ However, the problem is that few unions have obtained provisions significantly improving statutory rights. While some commentators infer from this that unions lack commitment to health and safety,⁴⁰⁹ there are alternative explanations. Lack of knowledge about the existence or extent of workplace hazards coupled with the fact that health and safety rights can challenge the way that work is organized in a particular workplace suggest that, even if unions were committed to occupational health and safety, it would be an uphill struggle to obtain significant improvements through bargaining.

Some early arbitral decisions denied collective agreement benefits to female workers for fertility health reasons on the basis that "the procreative needs of women are matters of choice rather than necessity."⁴¹⁰ Initially, an arbitrator held that treatment to induce ovulation for fertility purposes was not "necessary medical treatment" so as to warrant sick leave with full salary, since it was voluntarily undertaken by the employee.⁴¹¹ However, there are two more recent cases in which arbitrators considered *in vitro* fertilization procedures as treatment for a disability.⁴¹² Evidence was accepted that infertility is considered by medical standards to be an illness or disease. Thus, the treatment was viewed as an attempt to restore the griever's normal reproductive function (although voluntarily undertaken) and as the only means available to fulfil the griever's normal and natural desire to become pregnant.

3. Right to Refuse

Employees have the right to refuse unsafe work. Moreover, a collective agreement may provide specific entitlements to relocation and compensation in the event of removal for refusing to perform unsafe work. For a discussion of the arbitral jurisprudence concerning the right to refuse, both generally and in relation to reproductive health, see the section on Occupational Health and Safety Legislation at 2.2 and 2.3.

E. Conclusion

Because of its flexibility, collective bargaining has been advocated as a method for dealing with health and safety issues over government standard setting.⁴¹³ Nevertheless, health and safety generally, and reproductive health and safety in particular, cannot simply be delegated to collective bargaining, since over half of Canadian workers are not covered by collective agreements. Moreover, employment standards legislation is not a viable option because it provides very low standards and is not effectively enforced.⁴¹⁴ Thus, the most appropriate mechanisms for dealing with

reproductive hazards in the workplace are through occupational health and safety legislation and a general human rights prohibition against exclusionary policies discriminating against particular groups of workers.

VII. Recommendations and Alternatives

A. Introduction

As indicated in the introduction, existing legal categories result in policy fragmentation as regards the regulation of reproductive hazards at work and the compensation of occupationally induced reproductive injuries. This situation impedes the development of effective responses. To avoid this problem, we have organized this section on the basis of functional categories. First, there is the need to develop a set of equity principles to guide the development of all aspects of public policy in this area. These principles are addressed in the first section of our recommendations. The second section discusses prevention and makes a series of recommendations for improving current practices. The third section discusses compliance and enforcement programs. Finally, the last section makes recommendations respecting compensation for work-induced reproductive injury.

Before turning to our discussion of these topics, a few preliminary comments are in order. First, we have not attempted to draft statutory provisions or develop administrative arrangements for the implementation of our proposals. Rather, our proposals identify principles and suggest, in general terms, the legal and institutional mechanisms for their achievement. While we have tried to focus on reproductive hazards in particular, the fact is that improvements cannot be achieved in isolation from health and safety issues generally. A system of health and safety regulation that is unable to protect the general health of workers cannot be expected to protect adequately their reproductive health. Therefore, some of our proposals must touch on broader issues of regulatory effectiveness. At the same time, however, we also recognize that issues of reproductive health are not adequately dealt with within the existing systems, and, therefore, we have made recommendations aimed at improving their responsiveness to this particular problem.

Second, the development of a unified approach to regulation and compensation is impeded, but not precluded, by the constitutional division of powers between the federal and provincial governments. While it is unlikely that the federal jurisdiction will be enlarged to encompass all aspects of reproductive hazards at work, it is possible for the two levels of government to coordinate their efforts. This was demonstrated in the WHMIS project. A similar approach should be urged here.

Third, it is necessary to comment on the politics of regulatory reform. We recognize that many of our recommendations are unlikely to be imple-

mented in the current political and economic climate. Rather, we have sought to develop proposals that, in our view, will best achieve the goals of protecting workers from reproductive harm, compensating them when harm results, and doing this within an egalitarian framework. These are long-term objectives; they should provide guidance even while political compromises are struck and partial reforms enacted.

Finally, we are cognizant of changes taking place that significantly impact on the likelihood of individual jurisdictions undertaking regulatory initiatives. The intensification of global competition, fuelled by the Canada-United States free trade agreement, has a dampening effect on the ability of both provinces and nation states to develop regulatory strategies that significantly depart from current practices. The North American free trade agreement will intensify this negative pressure. Ultimately, solutions to the problem of possible and identified reproductive hazards at work may have to be developed through new multinational institutional mechanisms. Unfortunately, these mechanisms are not developing as rapidly as national sovereignty is eroding. In the meantime, regulatory reform must be achieved within the current constitutional, institutional, and political framework. Its prospects are uncertain.

B. Equity Principles

In developing our proposals, we have been guided by the principle of equity or non-discrimination. For too long, concerns about reproductive harm have detrimentally impacted on women's employment opportunities. Concerns about pregnant workers' well-being have led only to sporadic and sometimes misguided action.⁴¹⁵ Impressionistic or incomplete evidence has been invoked to justify policies excluding women from traditionally male-dominated workplaces, while more compelling evidence of reproductive harm in traditionally female occupations has been rejected as insufficient to support protective regulatory action. Moreover, while women are excluded from male workplaces, men are allowed to remain and be exposed to potential harms to their reproductive capacities and offspring.

In addition, the focus on fetal protection suggests that fetal health is more valuable than the health of adult workers. While fetuses are vulnerable to harm from workplace exposure, so too are adult workers. Moreover, there is mounting evidence suggesting that most substances or processes that are hazardous to a fetus or pregnant worker are also hazardous to all workers.

We believe all workers should have equal access to employment, equal treatment at work, and equal consideration with respect to health and safety standards. For this reason, we recommend that evidence that establishes, *prima facie*, that workers of either sex are at risk or can expose a fetus to harm should trigger the assumption that all workers are at risk from this substance or agent until proven otherwise. Moreover, the best way of ensuring equity in the workplace is not through discriminatory

personnel policies but by controlling reproductive hazards, first, by eliminating the hazard, and, second, by implementing engineering and work practice controls. To the extent that it is necessary, voluntary light duty and medical removal protection with retention of pay, seniority, and benefits should be guaranteed to all potential parents, including pregnant women; and medical removal policies should be written to protect the most vulnerable employees — pregnant and otherwise — from identified chemical, physical, and ergonomic hazards.

If we are concerned to protect the reproductive health of workers, we should be equally concerned to accommodate the needs of infertile workers undergoing fertility treatment. Since such treatment may interfere temporarily with employment responsibilities, employers should be required to accommodate their needs. These workers should be included in the voluntary light duty and protective removal provisions. And, finally, to ensure that medical monitoring is used neither to target particular workers nor unnecessarily to encroach on workers' human rights, employers should be required to justify any such system prior to its implementation.

C. Prevention

We have followed a number of basic public health principles when developing proposals for preventing reproductive harm. These principles suggest a hierarchy of measures that should be followed. Before proceeding, however, we want to emphasize the need to define properly the scope of preventive measures necessary to protect human health generally and reproductive health in particular. Too often, there has been a tendency to focus on discrete hazards, whether physical, chemical, or biological, and consideration of the latter two is of relatively recent origin. We must go beyond this approach and consider the work environment and its impact on human health in its totality. This requires that we also take into account the effect of work organization and design on workers' health, including the degree of control or influence workers exercise over the labour process, their ability to communicate with other workers, the degree of monotony, work scheduling, and the ergonomic design of the workplace.⁴¹⁶ The significance of these factors on reproductive health is only now beginning to be recognized, but given the complexity of human reproduction, it is likely that a holistic approach will be required to protect it from damage.⁴¹⁷

1. Reducing Risk Factors Present in the Workplace

This first measure requires that hazardous substances, processes, products, work arrangements, and conditions should not be introduced into the workplace and, if they are already present, that they be removed. In other words, ideally, we should aim to eliminate as many sources of risk in the workplace as we can, so that there is no greater danger at work than there is in the normal everyday activities citizens engage in voluntarily. A number of measures could be introduced to achieve this goal.

Prior testing should be required before new substances or agents that are likely to be harmful are introduced into the workplace. This requirement should not be limited to hazardous substances; reproductive hazards may be caused by physical agents, biological agents, psychosocial conditions, and ergonomics. Employers must be required to investigate the potential impact of their proposed production decisions on workers' health before those decisions are implemented, including whether they are likely to cause reproductive harms. Where information reveals the likelihood of harm to the workforce, then the change should be prohibited unless an adequate justification can be offered for permitting the hazard to be introduced. Adequate justifications might include the replacement of an even more hazardous substance, the ability to use the substance safely, or, perhaps, a claim about the social and human benefits of the change as measured against its social and human costs.

The proposed testing requirements under CEPA are a good beginning, but they must be reviewed to determine their adequacy with respect to detecting reproductive hazards. Also, they apply only to substances and not to other risk sources. Finally, when an assessment suggests that a substance may have harmful effects, CEPA fails to articulate the criteria that should be used by the minister in determining what consequences should result.

Second, employers should be required to assess thoroughly the health and safety effects of the existing work environment. This assessment should include testing of substances and agents already in use, but which have not been previously examined for their effect on human health. Alternatively, the duty to test could be placed on manufacturers and suppliers of currently used substances and agents. Testing protocols should ensure that reproductive health hazards are not overlooked. Further, given the enormity of the job, priorities should be established based on the likelihood and seriousness of harm and the extent of exposure. Where their use will expose workers to risks greater than those minor ones normally experienced on a voluntary basis by citizens in everyday activities, measures must be implemented to eliminate them. Immediate bans are one option; mandatory substitution with safer substances is another. Keeping the hazard in the workplace should be permitted only if the employer can provide adequate justifications of the sort suggested above.

Where preclusion or immediate elimination of risk sources is not possible, or their presence is justified, then control options must be considered.

2. Control Strategies

The first and most effective control strategy requires that design controls be developed to eliminate the risk at source. These may involve such measures as isolation, enclosure, use of specified control equipment, hygiene facilities, etc. This approach can be used without establishing

exposure limits, is easily enforceable, and avoids the problems that arise when complex mixtures of chemicals are in use. Ergonomic regulations and limits on shift work may also be considered a species of design strategy to avoid exposure to the risks from these potential sources of reproductive injury.

A second and less effective control strategy is to establish exposure limits and monitor them through environmental sampling and human monitoring (e.g., testing blood and urine to detect concentrations of harmful substances). However, these should be relied on only where design controls cannot totally eliminate exposure, and, when exposure levels are relied upon, it is crucial that certain principles be followed. For example, exposure limits should be fixed at levels that avoid harm to all workers exposed on a daily basis throughout their working lives. Regulations should allow exposures at higher levels only if the users can offer adequate justification for doing so. These justifications should be narrowly drawn; they might include such instances as very low risk of harm compared to large social benefits. In other words, the burden of proof that exposure at certain levels is safe, or otherwise should be permitted, must be placed on the employer — and the standard of proof should be a high one. Assessments of safety or risk/benefit claims must take into account the potential for reproductive harm to the exposed workforce, their partners, and their offspring.

Further, where it has been determined that exposure to more than ordinary risks is justified, this should be considered as a temporary measure. In this regard, we adopt the recent suggestion by Robert Sass that regulations should incorporate requirements for the employer to improve the level of safety over time.⁴¹⁸ This should be accomplished by moving up the hierarchy of preventive measures. Improvements could be achieved by reducing exposure levels, developing design control technologies to eliminate exposure, and ultimately eliminating the hazard from the workplace.

3. Discriminatory Standards, Exclusion, and Protective Reassignment

Finally, we consider whether exposure limits should be set at a level safe for most workers but not for others, and, if so, what rights especially vulnerable workers should enjoy. In our view, such exposure limits should be permitted, but only if certain conditions have been met:

- (a) There must be clear and compelling evidence that some workers are more vulnerable than others. In the area of reproductive hazards, it is especially important to ensure that the consequences of exposure to men are fully considered before any claim about women's reproductive capacity being at special risk is accepted.

- (b) There must also be clear and compelling evidence that eliminating the hazard, implementing design controls, or setting exposure limits at levels that would be safe for the most vulnerable are not feasible alternatives, and that the social benefits of allowing the hazard to remain are significantly greater than the potential harm that may result.
- (c) The employer should not be permitted to adopt exclusionary strategies. Rather, the most vulnerable workers should be given a right of protective reassignment or a right to compensation should other appropriate work not be available. Evidence from Quebec suggests that workers at risk will not need to be excluded if they are offered a suitable alternative. Compensation should be offered through the workers' compensation system, and, to reduce economic incentives for employers to discriminate against workers who might take up the right to compensation, the costs of such compensation should be distributed across all employers, as is the case in Quebec. However, to the extent that this arrangement inadvertently creates an incentive to compensate rather than accommodate, consideration should be given to the creation of a fund to subsidize accommodation costs incurred by individual employers.

4. Other Mechanisms

In our view, the principal mechanism for establishing standards for the prevention of harm to workers is through regulatory action pursuant to occupational health and safety laws. The common law courts should have little or no role to play in this regard. That is, the standard of care owed by an employer to an employee should be determined by reference to health and safety law, not tort law or the law of delict. Also, where WCBs become involved in prevention through penalty assessments, these assessments should be levied only for observed hazards or on the basis of safety audits. In either case, the standards relied on should be consistent with those established in health and safety law. Finally, we note that agreements on health and safety standards made between employers and workers, either in the context of the IRS or through collective bargaining, should be allowed to add to, but not detract from, publicly established standards. However, the existence of the opportunity to negotiate increased protection should not be relied on as an alternative to establishing public standards providing all workers with a high level of protection.

D. Compliance and Enforcement Programs

Effective regulation requires success at two levels. First, standards must be properly designed so that compliance will lead to a reduction of the targetted harm. In this regard, we have emphasized the importance of ensuring that reproductive hazards are taken into account in the develop-

ment of all standards. Second, there must be effective implementation of standards to achieve high compliance levels. Here we focus on this second objective. Of course, changes in this area will have to be made by the level of government with jurisdiction over health and safety at work. In the field of occupational health and safety regulation there has been an unfortunate tendency to tolerate substantial compliance deficits to the detriment of workers. The effective enforcement of measures protecting workers' reproductive health cannot be achieved in isolation. For this reason, our recommendations in this section are of a more general character.

1. Internal Responsibility

We discussed the components of the IRS earlier. Here, we wish to make some suggestions with respect to how it could be strengthened to make it more effective. Our emphasis is on strengthening worker rights in the IRS. The reasons for this are clear. At present, employers have the authority and power to make changes in the workplace, workers do not. Yet, it is workers' lives and health that are put at risk, not those of their employers. This is upside down — the imbalance between risk creators and risk bearers must be redressed if the IRS is to contribute in a meaningful way to the achievement of healthier and safer workplaces.

There are obviously severe political constraints on the changes that can be achieved, so we are suggesting only that the level of worker rights be raised to the next level. In that regard, we have used Sweden as a model.⁴¹⁹ First, workers should be given majority representation on joint health and safety committees. This is consistent with the view that the risk bearers have the most important stake in the work environment. Second, the health and safety committee should be more than an advisory body. At the very least, it should enjoy the power to make decisions with respect to company health services, including the appointment of company doctors. With respect to the implementation of prevention programs, any disagreement between the joint health and safety committee and the employer should be resolved by health and safety officials, with the burden on the employer to demonstrate why the majority view of the committee should not prevail. There must be an obligation on the employer to obtain approval from the joint health and safety committee of any significant changes to work processes, devices, premises, or substances that may impact on health and safety at work prior to their introduction. Of course, the impact on reproductive health must also be considered. If agreement cannot be reached, the dispute should be resolved in the manner described above.

Worker health and safety representatives should be given the right unilaterally to shut down operations where there are reasonable grounds to believe their continuation endangers workers. Employees whose work is stopped as a result of the shutdown should be deemed to be at work pending a determination of the matter by the inspector. If the inspector concurs with the view of the safety representative, the right to be paid should continue until the danger is eliminated. The right of workers to

refuse unsafe work should be strengthened by deeming refusing workers, and other workers whose work is stopped as a result of the refusal, to be at work. Workers who are at special risk should be given a right to reassignment or compensation if no appropriate work is available. Finally, worker right to know should be strengthened by extending WHMIS-type provisions to other hazards. While the right to know in and of itself may not improve compliance levels, it is a crucial pre-condition for the effective exercise of other worker rights we have recommended.

We are cognizant that giving workers stronger legal rights in the area of health and safety will not necessarily lead to a greater degree of worker activation. Workers are unlikely to exercise their legal rights in the absence of employment security. Protection against retaliation is inadequate if the worker is not also protected from discharge except for just cause. Even if this further right were given to non-unionized workers, the fear of retaliation may still remain. In non-union situations, or in small unionized workplaces, consideration should be given to the appointment of external safety delegates. These delegates would be workers with appropriate training who would represent workers in their region or industry with respect to health and safety matters in their workplaces. They would exercise the same powers as internal health and safety delegates, including the right to shut down dangerous work.

There are other factors that exert a negative influence on the willingness of workers to press their health and safety concerns. Workers in a declining industry, for example, might be afraid to assert their rights for fear it will result in an acceleration of job losses or plant shutdowns. These larger constraints on the IRS are, by and large, beyond the purview of health and safety law, but their existence does remind us that health and safety regulation is not immune to forces in the broader political economy. It is precisely for reasons such as these that external enforcement must remain the primary means through which compliance with health and safety standards is achieved.

2. State Enforcement of Occupational Health and Safety Laws

As noted in the report, insufficient resources are devoted to the enforcement of health and safety laws. More resources are required for any strategy to operate effectively. The predominant enforcement strategy of gentle persuasion, in conjunction with underfunding, results in a substantial compliance deficit. In our view, changes must be made on both accounts. Here, we focus on changes to the enforcement strategy.

Compliance orders are the most common form of intervention. They are overused relative to other instruments available to the inspector. Indeed, their frequency might create the impression that no wrong is committed until after there has been non-compliance with such an order. This undermines the seriousness with which employers should take their responsibilities under the law. Moreover, when compliance orders are used there must be appropriate follow-up. At the very least, there must be a

time limit within which the employer must remedy the violation. If a re-inspection cannot be arranged, the employer should be required to certify in writing that the required changes have been made. Where appropriate, the signature of an employee representative indicating agreement with the employer's certification might also be required.

Stop-work orders are effective because they put an immediate end to the activity identified as harmful. Although the employer is usually given some kind of administrative appeal from such an order, the changes are often made as soon as possible to bring the employer into compliance with the inspector's order — if only because the immediate costs resulting from the shutdown are greater than the costs of making the alterations. Workers should not have to bear the economic cost of shutdowns, and employers should be required to continue to pay employees whose work is disrupted for this reason.

Prosecution for violation of health and safety laws is currently used as a last resort and usually only when there has been a serious injury or death. To our knowledge, no employer has been charged for exposing a worker to a reproductive hazard. More vigorous enforcement should be considered. Indeed, there is evidence that punishment is effective in reducing harm to workers.⁴²⁰ Thus, for example, in many cases where stop-work orders are issued, it would also be appropriate to initiate a prosecution. The fact that luckily no one was hurt as a result of a dangerous condition the employer allowed to develop is not a reason for not prosecuting.

There are problems that must be faced in adopting a more prosecutorial enforcement strategy. No doubt, prosecutions consume resources, and underfunding of health and safety regulation is a serious problem. But, given the long history of gentle persuasion and the lack of evidence of its success, it is far from obvious that it would be inefficient to spend more scarce enforcement dollars on prosecution. Moreover, it is somewhat disingenuous for a government to justify its lack of vigour in enforcement on the basis of scarce resources when the government itself refuses to provide the additional resources needed for effective enforcement.

Beyond resource issues, however, there are legal obstacles that may be encountered by a more prosecutorial enforcement strategy. In the absence of clear standards, especially with respect to exposure to hazardous substances, courts may be hesitant to convict under general duties clauses.⁴²¹ Courts have expanded the defences available through the doctrine of due diligence and officially induced error.⁴²² Fines, on average, have not been high.

Yet these difficulties are not necessarily insurmountable. The case against prosecuting under the general duties clause is founded on a single decision of a provincial court judge in the context of a private prosecution. At the very least, the conclusion that it is not feasible is premature. Also, the fact that a defence is available does not mean that it can be easily used. In the case of due diligence, for example, the Supreme Court of Canada has

rejected arguments that would prohibit placing the onus on the defendant to prove on a balance of probabilities that due diligence had been exercised.⁴²³ As a result, the defence of due diligence may prove to be a difficult one for an employer to make out.⁴²⁴ Finally, at least on some occasions, courts have recognized the seriousness of employer misconduct and the need to impose fines that will have both general and specific deterrent effects.⁴²⁵ Since the changes to Ontario's health and safety act, large fines of up to \$400 000 have been imposed by the courts.⁴²⁶

The fact of the matter is that many of the arguments against the effectiveness of prosecution are not much more than unsubstantiated assertions that rationalize an unwillingness to actually try the enforcement route. Given the relative lack of success with gentle persuasion, perhaps the focus of discussion should now shift from the question of how to persuade to the question of how to punish.

In this regard, commentators have debated the relative merits of administrative penalties, prosecutions under health and safety laws, prosecution under the generally applicable provisions of the Criminal Code, and prosecution under special provisions that should be enacted into the Criminal Code. As well, there are questions that must be resolved about who in the corporation should be made responsible for misconduct.⁴²⁷ This is not the place to elaborate on the most appropriate punishment strategy. Rather, we emphasize the need to develop a commitment to use punishment and prosecution as an integral part of any effective enforcement strategy.

Finally, we make three recommendations specific to the enforcement of reproductive health standards. First, inspectors must be properly trained and instructed in the identification of reproductive hazards. Currently, no such training is provided. Second, there needs to be better integration of the duty to accommodate into health and safety standards and enforcement practices. Inspectors should be authorized to require employers to provide safe conditions for workers at greater than average risk. This could assist not only pregnant and breast-feeding women, but also male and female employees who are planning to have children. Third, we need to develop a mechanism for evaluating the results of our regulatory efforts. Workers' compensation claims based on injury rates are a flawed data source because of problems of coverage, claims recognition, and non-reporting. These difficulties make WCB data particularly unreliable as an indicator of reproductive injury rates. Moreover, WCB statistics are not arranged in such a way as to allow researchers to calculate reproductive injury rates. Urgent attention must be given to the development of a system for collecting the information necessary to enable governments, workers, and employers to identify problems and monitor change.

3. Workers' Compensation

Economic incentives administered through WCBs can be an effective instrument if they are appropriately designed. Experience rating and penalty assessments based on claims cost experience are undesirable techniques for prodding employers to adopt safe work practices. We

discussed these deficiencies earlier. Here, we need only recall the danger that employers will adopt a claims cost control strategy that entails the exclusion of women on the assumption that they are most likely to claim compensation for reproductive injuries. Other techniques, including penalty assessments based on observed hazards and health and safety audits, may be more effective and avoid the negative features discussed above. These instruments could be readily adapted to the control of reproductive hazards in the workplace. However, as with any public enforcement program, adequate public resources must be devoted to it.

It is noteworthy that the jurisdiction that uses this technique most effectively is British Columbia, where the WCB also has authority over health and safety regulation. The extent to which these instruments can be used effectively in jurisdictions where authority over compensation and health and safety is divided is an open question. For the program to be effective, however, the penalties must be imposed by the compensation authorities as a penalty assessment. Administrative sanctions imposed by health and safety agencies are likely to be less effective because the procedures for imposing them will necessarily become more formal. Further assessment of these mechanisms is required before firm recommendations can be made.

4. Tort Liability

We can see no role for tort liability in the development of a compliance strategy and on that basis do not recommend that the exclusive remedy provisions of workers' compensation statutes should be lifted. Nor, for that matter, do we see merit in tort liability as an instrument for inducing employers to adopt measures for the protection of the fetus. Aside from its deficiencies as a mechanism for compensating people who are harmed, there is virtually no evidence indicating that tort liability deters risky behaviour. Indeed, in the area of reproductive hazards, employers exposed to tort liability for work-induced harm to the offspring of workers have not responded by cleaning up their workplaces. Rather, they have excluded women of childbearing capacity.

E. Compensation

Our starting point for this discussion is that a just society should provide appropriate treatment and rehabilitation for all its members who become sick or injured. As well, economic losses should be compensated. We can see no merit to a system in which, to claim these entitlements, a person must first establish that someone else was at fault. For the purposes of entitlement to compensation and treatment, fault should be irrelevant. Nor, for that matter, can we recommend a system that requires a person to establish the cause of her or his disability as a condition precedent to establishing eligibility to these basic entitlements. For these reasons, we endorse a universal disability compensation scheme as a replacement for the tort and workers' compensation systems.⁴²⁸

We have already documented the inadequacy of the tort system as a mechanism for the compensation of reproductive injuries; for example, proof of legal causation is a virtually insurmountable barrier with respect to most reproductive injuries. The supposed advantage of the tort system in terms of the level of compensation awarded to the relatively few who succeed in establishing entitlement is exaggerated, especially in Canada, where courts have limited recovery for pain and suffering and punitive and exemplary damages. Moreover, any potential benefits are significantly outweighed by the pernicious effects of tort liability on women's employment. The claim that employers have a legitimate interest in avoiding liability to workers' children born with work-induced impairments has provided a justification for employment practices discriminating against women. This justification should be eliminated, and the opportunity for developmentally challenged children to enjoy a decent standard of living should not depend on the unlikely possibility that their parents' employers can be proven to have been at fault.

Workers' compensation is an improvement over the tort system because it eliminates one of the barriers to recovery — fault. It still requires, however, a finding that harm was *caused* by work. Even if the test of significant contributing factor or best available hypothesis is adopted, meeting the work-relatedness requirement for reproductive injuries will remain a difficult challenge. Because the etiology of reproductive impairment is complex, WCBs will continue to be pressed to refine their ability to draw artificial distinctions or to draw the line in a different place to allow more or fewer people to obtain compensation. The premise of the system is fundamentally flawed when applied to compensation for reproductive harm.

Therefore, rather than elaborate on incremental reforms, which will always be unsatisfactory, we think it is appropriate to emphasize the need to change fundamentally the basis on which people are compensated for disability, including reproductive impairment. As indicated above, we endorse the model of a universal compensation system providing all disabled citizens with appropriate treatment, rehabilitation, and compensation without regard to fault or causation. In the following paragraphs, we identify a few of the issues relevant to reproductive harm that need to be clarified. Incidentally, many of these issues must also be resolved in the workers' compensation system, and so the discussion will be apposite even if more fundamental reforms are not undertaken.

First, it must be determined what kind and level of treatment and rehabilitation will be provided. The ability of a society to pay is a factor that cannot be ignored in this decision-making process. However, it is likely that there will be a stronger commitment to the quality of universal programs from which all citizens might benefit if they are unfortunate than there is for targetted programs. There is also the question of efficacy of treatment. With respect to infertility, the question of which treatments ought to be provided is one of the central questions before the Royal

Commission on New Reproductive Technologies. Guidance will have to be provided to assist decision makers in the development of appropriate public policy. In addition to fertility treatment, appropriate counselling should be provided to persons with reproductive impairments to assist them in making appropriate decisions and in dealing with any psychological consequences of their disability. Individuals should be free to choose either medical or non-medical caregivers. The only requirement should be that the caregiver is qualified to provide appropriate treatment. Children who are developmentally challenged or who are otherwise disabled should be eligible to receive appropriate treatment, education, and rehabilitation.

Second, with respect to compensation, we recommend that only economic losses should be covered. Thus, workers should be paid for any wage loss suffered as a result of the injury and its treatment. Where there is permanent disability, wage losses should be calculated on the basis of the physical impairment method and not on the actual wage-loss system. While neither system is perfect, the former method eliminates the need for ongoing monitoring by an administrative agency and is less likely to interfere with rehabilitation.

We do not believe that workers should be compensated for pain and suffering, loss of consortium, or any other non-economic loss. We appreciate that this recommendation, like many others we have made, is controversial. There are a number of reasons we have adopted this position. To begin with, we think that great harm is caused by trying to place a monetary value on losses that are inherently inestimable. Aside from the sheer difficulty of doing this, the results are unavoidably arbitrary. What is the monetary value of the loss of reproductive capacity? Should we try to calculate it individually after considering how important having children was to the injured person and, perhaps, his or her partner? Should the amount be reduced if the person already is a parent, or should the amount be increased because of the loss of companionship suffered by the child who will not have a brother or sister? In our view, the very process of monetizing these kinds of losses cheapens them and encourages a pernicious tendency in our society to reduce even the most basic human emotions to exchangeable commodities. Finally, we might ask, does money actually compensate people who have suffered these harms? Does a person who has lost her or his reproductive capacity feel better because he or she has been given \$10 000? Would that person feel even better if the award was increased to \$30 000?

Perhaps what really drives the demand for compensation for non-economic loss is the belief that wrongdoers should be made to pay for the harm they have caused. But if we accept that entitlement to compensation should not be contingent on fault, the force of this rationale is diminished. We agree that wrongdoers should be punished, but the tort system is not an appropriate way to do it. Deterrence objectives can be achieved more effectively through prosecutions.

To the extent that the political demand for compensation for non-economic losses cannot be resisted, we recommend the flat functional loss system used in workers' compensation in Quebec and Ontario as the least worst alternative. The extent to which loss of reproductive function and other related reproductive losses are covered under those systems, however, requires further review.

Finally, it will be necessary to decide how to fund a universal disability compensation system. In particular, to what extent should it be funded by employers, motor vehicle users, or general revenues? We have not formulated a concrete proposal in this regard, but it would seem logical to have employers bear some of the costs based on a rough calculation of the contribution of work to human disability.

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Table of Acronyms

ACGIH	American Conference of Governmental Industrial Hygienists
BFOQ	<i>Bona fide</i> occupational qualification
CEPA	Canadian Environmental Protection Act
CSST	Commission de la santé et de la sécurité du travail
DBCP	Dibromochloropropane
EEOC	Equal Employment Opportunity Commission
HRC	Human Rights Commission
IRS	Internal responsibility system
MSDS	Material safety data sheet
NIOSH	National Institute of Occupational Safety and Health
OHSA	Occupational Health and Safety Act
OSHA	Occupational Safety and Health Administration
PPD	Permanent partial disability
SLEL	Suffering and loss of enjoyment of life
TLV	Threshold limit value
TPD	Temporary partial disability
TTD	Temporary total disability
VDT	Video display terminal
WCAT	Workers' Compensation Appeal Tribunal
WCB	Workers' Compensation Board
WHMIS	Workplace Hazardous Materials Information System
WHSAs	Workplace Health and Safety Agency

Notes

1. E. Tucker, *Administering Danger in the Workplace: The Law and Politics of Occupational Health and Safety Regulation in Ontario, 1850-1914* (Toronto: University of Toronto Press, 1990), 82-96; N.M. Chenier, *Reproductive Hazards at Work: Men, Women and the Fertility Gamble* (Ottawa: Canadian Advisory Council on the Status of Women, 1982), 39-41.
2. Chenier, *op. cit.*, 41-42.
3. U.S. Congress, Office of Technology Assessment, *Reproductive Health Hazards in the Workplace* (Washington, DC: U.S. Government Printing Office, 1985), 244; E. Draper, *Risky Business: Genetic Testing and Exclusionary Practices in the Hazardous Workplace* (Cambridge: Cambridge University Press, 1991), 65-71.
4. U.S. Congress, *op. cit.*, 235.
5. International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, *UAW v. Johnson Controls*, 111 S. Ct. 1196 (1991).
6. R. Rosen, "What Feminist Victory in the Court," *New York Times* (1 April 1991): A17.
7. K.E. Swinton, "Accommodating Women in the Workplace: Reproductive Hazards and Seniority Systems," *Canadian Labour Law Journal* 1 (1990): 125-39.

8. S. Klitzman et al., "A Women's Occupational Health Agenda for the 1990's," *New Solutions* 1 (Spring 1990), 10.
9. *Wiens v. Inco Metals Co.* (1988), 9 C.H.R.R. D/4795 (Ont.) (Cumming).
10. M.H. Rioux, "Safety and Risk," *Just Cause* 2 (1984), 13.
11. Klitzman et al., *supra*, note 8, 10.
12. U.S. Congress, *supra*, note 3, 335.
13. For overviews of the range of potential reproductive hazards in the workplace, see Chenter, *supra*, note 1, chap. 2; and U.S. Congress, *supra*, note 3, chap. 4. More recent research reports on the relation between work and reproductive health include A.D. McDonald et al., "Occupation and Pregnancy Outcome," *British Journal of Industrial Medicine* 44 (1987): 521-26; M.J. Saurel-Cubizolles and M. Kaminski, "Pregnant Women's Working Conditions and Their Changes During Pregnancy: A National Study in France," *British Journal of Industrial Medicine* 44 (1987): 236-43; L. Goulet and G. Thériault, "Association Between Spontaneous Abortion and Ergonomic Factors: A Literature Review of the Epidemiologic Evidence," *Scandinavian Journal of Work and Environmental Health* 13 (1987): 399-403; M.J. Rosenberg, P.J. Feldblum, and E.G. Marshall, "Occupational Influences on Reproduction: A Review of Recent Literature," *Journal of Occupational Medicine* 29 (1987): 584-91; N. Cherry, "Physical Demands of Work and Health Complaints Among Women Working Late in Pregnancy," *Ergonomics* 30 (1987): 689-701; A.D. McDonald et al., "Fetal Death and Work in Pregnancy," *British Journal of Industrial Medicine* 45 (1988): 148-57; A.D. McDonald et al., "Prematurity and Work in Pregnancy," *British Journal of Industrial Medicine* 45 (1988): 56-62; A.D. McDonald et al., "Congenital Defects and Work in Pregnancy," *British Journal of Industrial Medicine* 45 (1988): 581-88; N. Mamelle, I. Bertucat, and F. Munoz, "Pregnant Women at Work: Rest Periods to Prevent Preterm Birth," *Paediatric and Perinatal Epidemiology* 3 (1989): 19-28; B.G. Armstrong, A.D. Nolin, and A.D. McDonald, "Work in Pregnancy and Birth Weight for Gestational Age," *British Journal of Industrial Medicine* 46 (1989): 196-99; G. Axelsson, R. Rylander, and I. Nolin, "Outcome of Pregnancy in Relation to Irregular and Inconvenient Work Schedules," *British Journal of Industrial Medicine* 46 (1989): 393-98; C.J. Homer, S.A. James, and E. Siegel, "Work-Related Psychosocial Stress and Risk of Preterm, Low Birth-weight Delivery," *American Journal of Public Health* 80 (1990): 173-77; and H.K. Taskinen, "Effects of Parental Occupational Exposures on Spontaneous Abortion and Congenital Malformation," *Scandinavian Journal of Work and Environmental Health* 16 (1990): 297-314.
14. T.O. McGarity, "Substantive and Procedural Discretion in the Administrative Resolutions of Science Policy Questions: Regulating Carcinogens in EPA and OSHA," *Georgetown Law Journal* 67 (1978-79): 729-810.
15. Risk assessments include: (1) hazard identification, (2) dose-response assessment, (3) exposure assessment, and (4) risk characterization.
16. For example, see the studies referred to in note 13.
17. For an extended discussion, see R.R. Faden and T.L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986).
18. P.W. Brandt-Rauf and S.I. Brandt-Rauf, "Ethical Aspects of Reproductive Health in the Workplace," *Occupational Medicine* 1 (1986): 509-15.

19. Canada, Statistics Canada, *Work Injuries 1988-90* (Ottawa: 1992). For older data, see P. Rohan, "The Trend of Work Injuries in Canada," *Family Physician* 24 (1978): 576.
20. T.G. Ison, *Compensation for Industrial Disease Under the Workers' Compensation Act of Ontario* (Toronto: Industrial Disease Standards Panel, 1989).
21. P.C. Weiler, *Protecting the Worker from Disability: Challenges for the Eighties* (Toronto: Ontario Ministry of Labour, 1983), chap. 2.
22. Canada, Labour Canada, *Employment Injuries and Occupational Illnesses* (Ottawa: 1990).
23. E. Tucker, "The Persistence of Market Regulation of Occupational Health and Safety: The Stillbirth of Voluntarism," in *Essays in Labour Relations Law*, ed. G. England (Don Mills: CCH Canadian, 1986).
24. Tucker, *supra*, note 1.
25. N.M. Chenier, *The Selective Protection of Canadian Working Women* (Ottawa: Labour Canada, Women's Bureau, 1989); and M. Levitsky, "Protecting Workers from Reproductive Hazards," *Canadian Journal of Women and the Law* 1 (1986): 488-97.
26. For overviews of these changes, see K.E. Swinton, "Enforcement of Occupational Health and Safety Legislation: The Role of the Internal Responsibility System," in *Studies in Labour Law*, ed. K.P. Swan and K.E. Swinton (Toronto: Butterworths, 1983), 143-75; and E. Tucker, *supra*, note 23.
27. For an overview, see R.M. Brown, "Canadian Occupational Health and Safety Legislation," *Osgoode Hall Law Journal* 20 (1982), 90-93.
28. Controlled Products Regulations, SOR/88-66, s. 33.
29. A teratogen is an agent that interferes with embryonic or fetal development. An embryotoxin is an agent that adversely affects the embryo by interrupting the normal function of a cell, tissue, or organ. A reproductive toxin is an agent that interferes with reproduction or procreative functioning of the adult from puberty through adulthood. A mutagen is a substance that induces mutation in the genetic material. See U.S. Congress, *supra*, note 3, ix-xiv.
30. Controlled Product Regulations, *supra*, note 28, ss. 53, 55, 57, and 62. The technical adequacy of the criteria is beyond our expertise to evaluate.
31. For example, see "A Matter of WHMIS Enforcement," *At the Source* 10 (2) (1989-90): 8-10; and W. Roberts, "Poison Playoff," *Now* (2-8 November 1989): 8.
32. Generally, see G. Leslie, "The Statutory Right to Refuse Unsafe Work: A Comparison of Saskatchewan, Ontario, and the Federal Jurisdiction," *Saskatchewan Law Review* 46 (1981-82): 235-70; R. Brown, "The Right to Refuse Unsafe Work," *University of British Columbia Law Review* 17 (1983): 1-34; Swinton, *supra*, note 26, 160-69; S. Williams, "The Right to Refuse," *Occupational Health & Safety Canada* 4 (January-February 1988): 20-27; M. Renaud and C. St-Jacques, "The Right to Refuse in Quebec: Five-Year Evolution of a New Mode of Expressing Risk," *International Journal of Health Services* 18 (1988): 401-17; and V. Walters, "State Mediation of Conflicts over Work Refusals: The Role of the Ontario Labour Relations Board," *International Journal of Health Services* 21 (1991): 717.
33. *Re Steel Co. of Canada Ltd. and United Automobile Workers, Local 1005* (1973), 4 L.A.C. (2d) 315 at 318 (Ont.) (Johnston).

34. On this point, and on the rationale for and operation of the right to refuse unsafe work, see *Pharand v. Inco Metals Co.*, [1980] 3 C.L.R.B.R. 194 (Ont.).
35. *Ibid.*, 194.
36. For example, see *Evratre v. Ottawa (City)*, [1986] O.L.R.B. Rep. 798 at para. 21.
37. This was the case in the federal jurisdiction prior to 31 March 1986. The standard remains in Alberta and Newfoundland.
38. J.M. Brown and D.M. Beatty, *Canadian Labour Arbitration*, 3d ed. (Aurora: Canada Law Book, 1991), 7:3621.
39. The handling of this issue in Quebec is discussed in detail in Renaud and St-Jacques, *supra*, note 32, 412-14. More recently, as a result of a complaint to the Ontario Human Rights Commission and an appeal to the adjudicator, the Ontario Ministry of Labour instigated a review of its policies and procedures relating to the investigation of work refusals. A draft policy was issued in April 1992 and is being used as an interim policy. It allows the inspector to base decisions with respect to work refusals on the criterion of whether the condition of the workplace is likely to endanger the health of the particular worker based on particular health conditions. Obviously, this would be particularly relevant to workers who are at increased risk at a particular stage of the reproductive cycle.
40. For Ontario, see Tucker, *supra*, note 23, 235, and for Quebec, see Renaud and St-Jacques, *supra*, note 32, 403.
41. For a recent example, see *Letwyn v. Versatile Farm Equipment Operations* (1991), C.E.S.H.G. par. 95,215 (Man. L.R.B.).
42. Ontario, Ministry of Labour, *Occupational Health and Safety Facts and Figures 1990-1991* (1991).
43. N.A. Keith, *Ontario Health and Safety Law: A Comprehensive Guide to the Statute, Case-Law, Policy and Procedures* (Aurora: Canada Law Book, 1991); 7-29 - 7-36.
44. *Nugent v. Bell Canada*, [1982] 1 C.L.R.B.R. 416, and *Sibley v. Atomic Energy Board of Canada* (1983), 3 C.L.R.B.R. (N.S.) 409.
45. See K.E. Swinton, "Regulating Reproductive Hazards in the Workplace: Balancing Equality and Health," *University of Toronto Law Journal* 33 (1983), 69-71.
46. M.-L. Lindbohm et al., "Magnetic Fields of Video Display Terminals and Spontaneous Abortion," *American Journal of Epidemiology* 136 (1992): 1041-51.
47. A risk to the fetus is likely to be considered a risk to the mother for the purpose of a work refusal. For example, this interpretation has been adopted by the Ontario Ministry of Labour.
48. Occupational Health and Safety Act, R.S.O. 1990, c. O.1, ss. 44-48.
49. For example, see SPR Associates, "An Evaluation of Joint Health and Safety Committees in Ontario: As Based on Mail Surveys of Worker and Management Members of Joint Health and Safety Committees in Over 3,000 Industrial, Mining, Educational and Health Workplaces," in Ontario, Advisory Council on Occupational Health and Occupational Safety, *Eighth Annual Report*, vol. 2 (1986).
50. For example, see R. Sass, "A Critique: Canadian Public Policy in Workplace Health and Safety," *New Solutions* 2 (Fall 1991): 39-46.

51. For example, see Swinton, *supra*, note 26, 159.
52. V. Walters and T. Haines, "Workers' Use and Knowledge of the 'Internal Responsibility System': Limits to Participation in Occupational Health and Safety," *Canadian Public Policy* 14 (1988): 411-23.
53. Alberta, Alberta Occupational Health and Safety, *Medical Guidelines*, MSB/36 (June 1988), MSB/38 (June 1988), and MSB-06 (January 1992) (Edmonton).
54. S.C. 1988, c. 22, ss. 25-32.
55. Occupational Health and Safety Act, *supra*, note 48, s. 34.
56. *Ibid.*, ss. 33 and 70(2).
57. Ontario data provided in letter from Tim Millard, Assistant Deputy Minister, Ontario Ministry of Labour, to Eric Tucker (13 April 1992); An Act respecting Occupational Health and Safety, S.Q. 1979, c. 63, s. 64.
58. Occupational Health and Safety Act, *supra*, note 48, s. 54(1)(e)(f).
59. *Ibid.*, s. 33, and An Act respecting Occupational Health and Safety, *supra*, note 57, s. 65.
60. Canada Occupational Safety and Health Regulations, SOR/86-304, s. 10.5 as amended.
61. One exception is with respect to asbestos on construction sites and in buildings. See O. Reg. 654/85.
62. For a selection of works discussing various aspects of the difficulties of standard setting, see T. Schrecker, *The Pitfalls of Standards* (Hamilton: Canadian Centre for Occupational Health and Safety, 1986); J. Mendeloff, *Regulating Safety: An Economic and Political Analysis of Occupational Safety and Health Policy* (Cambridge: MIT Press, 1979); N. Cunningham, *Safeguarding the Worker: Job Hazards and the Role of the Law* (Sydney: Law Book, 1984), 313-22; E. Tucker, "The Determination of Occupational Health and Safety Standards in Ontario, 1860-1982: From the Market to Politics to ...?" *McGill Law Journal* 29 (1984), 286-309; and McGarity, *supra*, note 14.
63. N.S. Reg. O.C. 76-1510 and O. Reg. 654/86.
64. B.I. Castleman and G.E. Ziem, "Corporate Influence on Threshold Limit Values," *American Journal of Industrial Medicine* 13 (1988): 531-59; G.E. Ziem and B.I. Castleman, "Threshold Limit Values: Historical Perspectives and Current Practice," *Journal of Occupational Medicine* 31 (1989): 910-18; and S.A. Roach and S.M. Rappaport, "But They Are Not Thresholds: A Critical Analysis of the Documentation of Threshold Limit Values," *American Journal of Industrial Medicine* 17 (1990): 727-53. For a more positive assessment, see L. Salter, E. Levy, and W. Liess, *Mandated Science: Science and Scientists in the Making of Standards* (Dordrecht: Kluwer, 1988), 36-66.
65. Despite the criticisms launched against this claim, it is retained in the most recent edition. See American Conference of Governmental Industrial Hygienists (ACGIH), *Documentation of the Threshold Limit Values and Biological Exposure Indices*, 6th ed. (Cincinnati: ACGIH, 1991), iii.
66. J.Y. Levy, "A Study of the Acceptable Risk Policies to Regulate Occupational Exposures to Carcinogenic Substances in Canada and the United States: Does a

- Lifetime Risk of One Excess Cancer Death per Thousand Workers Constitute an Acceptable Level of Risk?" Ph.D. dissertation, Clark University, 1991, 225-69.
67. Code for Medical Surveillance for Lead, O. Reg. 536/81 as amended. The provisions are contained in ss. 4(1) & 5. The Code was not gazetted with the regulation.
68. Swinton, *supra*, note 45, and C. Tuohy, "Decision Trees and Political Thickets: An Approach to Analysing Regulatory Decision-Making in the Occupational Health Arena," Law and Economics Workshop Series, No. WSVI-15 (Toronto: University of Toronto, Faculty of Law, 1984) and C. Tuohy, "Procedural Rationality and Regulatory Decision-Making: A Decision Framework Approach," *Law & Policy* 7 (1985): 354-73.
69. Chenier, *supra*, note 25, 16-22, and Levitsky, *supra*, note 25, 490.
70. Atomic Energy Control Regulations, SOR/74-334.
71. Atomic Energy Control Regulations, Amendment, SOR/85-335.
72. Code for Medical Surveillance for Mercury, O. Reg. 141/82, s. 5.
73. For example, see A.F. Olshan, K. Teschke, and P.A. Baird, "Paternal Occupation and Congenital Anomalies in Offspring," *American Journal of Industrial Medicine* 20 (1991): 447-75 and S. Blakeslee, "Research on Birth Defects Shifts to Flaws in Sperm," *New York Times* (1 January 1991): A1.
74. Cited in N. Cunningham and C. Winder, "Protective Legislation and Discrimination in Employment in the Australian Lead Processing Industries: Implications for Future Nondiscriminatory Legislation," *Journal of Occupational Health and Safety — Australia and New Zealand* 4 (1988), 177.
75. Ontario, Advisory Council on Occupational Health and Occupational Safety (ACOHOS), *Fourth Annual Report 1981-82* (Toronto: 1982), 75-113.
76. Ontario, ACOHOS, *Fifth Annual Report, 1982-83* (Toronto: 1983), 20-46.
77. O. Reg. 176/86 (arsenic), O. Reg. 732/84 (benzene), and O. Reg. 146/87 (ethylene oxide).
78. J. Penney, "Negotiating Ontario Standards," *New Solutions* (Fall 1991): 9-14.
79. For example, in 1899 the Ontario Executive Committee of the Dominion Trades and Labour Congress, referring to the Factory Acts, complained, "There is, in the opinion of the Committee, some of the best labour legislation in the country on the books of Ontario, but it is almost impossible to have it enforced." Cited in Tucker, *supra*, note 1, 175.
80. For a small sample, see J. Braithwaite, *To Punish or Persuade: Enforcement of Coal Mine Safety* (Albany: State University of New York Press, 1985); D.J. Lofgren, *Dangerous Premises: An Insider's View of OSHA Enforcement* (Ithaca: ILR Press, 1989); T. Ison, "The Uses and Limits of Sanctions in Industrial Health and Safety," *Workers' Compensation Reporter* 2 (1975-76), 203; R. Brown and M. Rankin, "Persuasion, Penalties and Prosecution: Administrative v. Criminal Sanctions," in *Securing Compliance: Seven Case Studies*, ed. M.L. Friedland (Toronto: University of Toronto Press, 1990), 325; and H.J. Glasbeek, "A Role for Criminal Sanctions in Occupational Health and Safety," in *New Developments in Employment Law* (Meredith Memorial Lectures 1988) (Montreal: Éditions Yvon Blais, 1989), 125.

81. G.G. McKenzie and J.I. Laskin, *Report on the Administration of the Occupational Health and Safety Act*, vol. 1 (Toronto: Ontario Ministry of Labour, 1987), xii.
82. *Ontario Public Service Employees' Union v. Ontario (Ministry of Labour)* (unreported decision of W.S. Melinshyn, Director, Industrial Health and Safety Branch, 20 October 1982).
83. It should be noted that this average reflects the situation prior to Bill 208 when the maximum fine was \$25 000. It has been raised to a maximum of \$500 000 for corporations, and the level of fines imposed seems to be rising. Whether the fines are ever collected is a separate issue.
84. Law Reform Commission of Canada, *Workplace Pollution*, Working Paper 53 (Ottawa: LRC, 1986), 59.
85. Brown and Rankin, *supra*, note 80.
86. Indeed, the health and safety inspectors themselves, through their union, OPSEU, have asserted that, "the IRS cannot work on its own without the assistance of a firm system of external enforcement" (emphasis in the original). See Ontario Public Service Employees Union, "Submission of the Health and Safety Inspectors of the Ontario Public Service Employees Union to the Standing Committee on Resources Development Regarding An Act to Amend the Occupational Health and Safety Act and Workers' Compensation Act" (Toronto: 16 February 1990).
87. Swinton, *supra*, note 26, 154.
88. See Tucker, *supra*, note 23, 243-44.
89. Throughout this section we have relied extensively on T.G. Ison, *Workers' Compensation in Canada*, 2d ed. (Toronto: Butterworths, 1989). We have not, however, footnoted the numerous individual references. For Ontario, see G. Dee, N. McCombie, and G. Newhouse, *Workers' Compensation in Ontario* (Toronto: Butterworths, 1987).
90. Workers can be disqualified if their injuries result from certain kinds of misconduct on their part. Very few claims are denied on this basis.
91. On the dimensions, see studies referred to in note 13. While there are no Canadian studies of workers' compensation for reproductive impairment, the conclusion of the OTA study, *supra*, note 3, was that: "the workers' compensation and tort liability systems fail to consistently provide compensation to the victims of occupationally induced reproductive failure, though they sometimes result in some compensation for some workers" (p. 279).
92. Ison, *supra*, note 89, 16, argues that there is scope in the language of some compensation statutes to argue that disabled children are eligible for compensation, but it seems unlikely that such claims would succeed. For example, the Ontario board has adopted a policy expressly denying liability for injury to the fetus. See Ontario, Workers' Compensation Board, *Operational Policy Manual* (Toronto), 03-03-09. The British Columbia WCB has adopted a similar position.
93. For example, see Workmen's Compensation Act, R.S.O. 1980, c. 539, s. 3(1).
94. For example, see U.S. Congress, *supra*, note 3, 3, which summarizes its findings in this regard as follows:

What is known about reproductive health hazards is far outweighed by what is unknown: most commercial chemicals and physical factors have

not been thoroughly evaluated for their possible toxic effects on reproduction and development. Much of the information on suspected reproductive health hazards, as with other hazards, is derived from animal studies, which present problems of interpretation in extrapolating to effects in humans (emphasis in original).

95. For discussion of this problem and others, see P.S. Barth with A. Hunt, *Workers' Compensation and Work-Related Illnesses and Diseases* (Cambridge: MIT Press, 1980), 9-15.
96. T.G. Ison, *The Dimensions of Industrial Disease, Research and Current Issues Series No. 35* (Kingston: Queen's University, Industrial Relations Centre, 1978), 1-4.
97. Ison, *supra*, note 89, 206-207, and Ison, *supra*, note 20, 4-6.
98. Ison, *supra*, note 89, 207-209, 217-19, and Ison, *supra*, note 20, 6-7, 23-30.
99. For a good review of the issues, see Ontario, Workers' Compensation Board, *Discussion Paper: Work-Relatedness in the Workers' Compensation System* (Toronto: 1990), and the articles in *Compensation Appeals Forum* 4 (1)(1989).
100. Generally, on the compensation of disease claims in Ontario, see A. Yassi, "Occupational Disease and Workers' Compensation in Ontario" (Report prepared for Professor Paul C. Weiler in his study of Workers' Compensation in Ontario, n.d.), and Ontario, Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario, Report (Toronto: Queen's Printer, 1984) (Chair: J. Stéfan Dupré), 687-700.
101. Workers' Compensation Act, R.S.O. 1990, c. W.11, s. 134(1).
102. For example, see *Re Evans and Workers' Compensation Board* (1982), 138 D.L.R. (3d) 346 (B.C.C.A.).
103. R.R.O. 1980, Reg. 951.
104. For a strong critique, see Ison, *supra*, note 20, 16-21.
105. Workers' Compensation Act, *supra*, note 101, s. 1(1).
106. *Decision No. 850* (1988), (Ont. WCAT), 14.
107. A. Farquhar, "WCAT on the New Frontier — Stress and Occupational Disease," *Compensation Appeals Forum* 4 (1)(1989), 27.
108. For an overview, see K. Lippel, "Workers' Compensation and Psychological Stress Claims in North American Law: A Microcosmic Model of Systemic Discrimination," *International Journal of Law and Psychiatry* 12 (1989): 41-70.
109. For a review, see Lippel, *op. cit.*, 53-64.
110. *Decision No. 918* (1988) (Ont. W.C.A.T.). For a critical comment on this decision, see Farquhar, *supra*, note 107, 25.
111. For example, in Ontario see *Operational Policy Manual*, *supra*, note 92, 03-03-09. Also, there is an unreported decision of the Director of Appeals of the British Columbia WCB awarding medical aid for pregnancy complications and tubal ligation.
112. For a general assessment of the merits of these two systems, particularly in relation to the calculation of periodic payments, see T.G. Ison, "The Calculation of

- Periodic Payments for Permanent Disability," *Osgoode Hall Law Journal* 22 (1984): 735-52.
113. *Decision No. 95* (1975), 2 W.C.R. 6 (B.C.).
 114. *Decision No. 157* (1975), 2 W.C.R., 198 (B.C.).
 115. *Ibid.*, 199.
 116. *Operational Policy Manual*, *supra*, note 92, 03-03-10.
 117. *Decision No. 785/88* (10 April 1989), (Ont. W.C.A.T.).
 118. *Decision No. 785/88R* (1991), 19 W.C.A.T.R. 61 (Ont. W.C.A.T.).
 119. *Decision No. 785/R* (1992), 21 W.C.A.T.R. 1 (Ont. W.C.A.T.), 3.
 120. Alberta, Workers' Compensation Board, *Claims Department Manual* (Edmonton), ADJ-11.
 121. *Decision No. 157*, *supra*, note 114, 201.
 122. *Operational Policy Manual*, *supra*, note 92, 03-03-10.
 123. *Ibid.*
 124. *Claims Department Manual*, *supra*, note 120.
 125. *Ibid.*, ADJ-40.
 126. O.C. 1291-87, 19 August 1987, G.O.Q. 1987.II.3270 (An Act respecting Industrial Accidents and Occupational Diseases).
 127. Engelberg, A.L., ed., *Guides to the Evaluation of Permanent Impairment*, 3d ed. (Chicago: American Medical Association, 1988), chap. 11.
 128. On the theory, see J.R. Chelius, "The Influence of Workers' Compensation on Safety Incentives," *Industrial and Labor Relations Review* 35 (1982): 235-42.
 129. For discussion, see P.S. Atiyah, "Accident Prevention and Variable Premium Rates for Work-Connected Accidents," *Industrial Law Journal* 4 (1975): 1-11; 89-105.
 130. For Ontario, see D. Derstine and S. Nathu, "Workers' Compensation in Ontario: A Decade of Reform," *University of Toronto Faculty of Law Review* 48 (1990), 22, 37-46.
 131. For a powerful critique, see T.G. Ison, "The Significance of Experience Rating," *Osgoode Hall Law School* 24 (1986): 723-42.
 132. J.R. Chelius and R.S. Smith, "Experience-Rating and Injury Prevention," in *Safety and the Work Force: Incentives and Disincentives in Workers' Compensation*, ed. J.D. Worrall (Ithaca: ILR Press, 1983).
 133. Atiyah, *supra*, note 129, 98-102.
 134. See Ison, *supra*, note 80, and Brown and Rankin, *supra*, note 80.
 135. L. Papp, "Worker-Safety Groups Called Costly Failure," *Toronto Star* (12 July 1991): A12.
 136. Occupational Health and Safety Act, *supra*, note 48, ss. 13-19.
 137. Workers' Compensation Act, *supra*, note 101, s. 1(n)(iii).
 138. Dee et al., *supra*, note 89, 90.

139. *Operational Policy Manual*, *supra*, note 92, 02-04-20.
140. Code for Medical Surveillance for Lead, *supra*, note 67, s. 16(2), Code for Medical Surveillance for Mercury, *supra*, note 72, s. 16(2), and *Operational Policy Manual*, *supra*, note 92, 04-04-18.
141. Prince Edward Island has also awarded compensation on this basis, including compensation to pregnant workers who were required to stay out of freshly painted areas.
142. *Decision No. 3* (1973), 1 W.C.R. 11 (B.C.).
143. *Decision No. 38* (1974), 1 W.C.R. 157 (B.C.).
144. An Act respecting Occupational Health and Safety, *supra*, note 57, ss. 32-48.
145. An Act respecting Occupational Health and Safety, S.Q. 1985, c. 6, s. 528.
146. G. Turcotte, "How Pregnant Workers See Their Work, Its Risks and the Right to Precautionary Leave in Quebec," *Women and Health* 18 (1992), 80.
147. Québec, Commission de la santé et de la sécurité du travail, *Rapport annuel* (Quebec: CSST, 1989).
148. R. Malenfant, "Evolution of the Participation of Women in the Workforce in Quebec," *Round Table* (1993 forthcoming).
149. Turcotte, *supra*, note 146, 80-81.
150. S. Bélanger, "Le retrait préventif de la travailleuse enceinte," *Canadian Journal of Women and the Law* 1 (1986): 498-504, and G. Trudeau and J.-P. Villagi, "Le retrait préventif de la femme enceinte en vertu de la Loi sur la santé et la sécurité du travail: où en sommes-nous?" *Revue du Barreau* 46 (1986): 477-502.
151. Malenfant, *supra*, note 148.
152. Turcotte, *supra*, note 146.
153. J.-G. Castel, *The Civil Law System of the Province of Quebec: Notes, Cases, and Materials* (Toronto: Butterworths, 1962), 1.
154. The following discussion is based on U.S. Congress, *supra*, note 3.
155. L.N. Klar, *Tort Law* (Toronto: Carswell, 1991), 1.
156. Ibid., 2.
157. The following discussion derives from Klar, *op. cit.*, and H.J. Glasbeek and R. Hasson, "Fault — The Great Hoax," in *Studies in Canadian Tort Law*, ed. L.N. Klar (Toronto: Butterworths, 1977).
158. Reputation and privacy, for example.
159. Klar, *supra*, note 155, 18.
160. S.D. Sugarman, "Doing Away with Tort Law," *California Law Review* 73 (1985): 555-664; P.S. Atiyah, "No-Fault Compensation: A Question That Will Not Go Away," *Insurance Law Journal* 694 (1980): 625-40; T.G. Ison, "The Politics of Reform in Personal Injury Compensation," *University of Toronto Law Journal* 27 (1977): 385-402.
161. T.G. Ison, "Human Disability and Personal Income," in *Studies in Canadian Tort Law*, ed. L.N. Klar (Toronto: Butterworths, 1977); New Zealand, Royal

Commission of Inquiry into Compensation for Personal Injury in New Zealand, Report (1967).

162. *Cook v. Lewis*, [1951] S.C.R. 830 at 839.
163. J.G. Fleming, *The Law of Torts*, 7th ed. (Sydney: Law Book, 1987), 23.
164. Klar, *supra*, note 155, 38.
165. *Ibid.*, 40.
166. *Ibid.*, 41.
167. Fleming, *supra*, note 163, 95.
168. [1932] A.C. 562 (H.L.).
169. *Ibid.*, 580.
170. Klar, *supra*, note 155, 116.
171. *Rivetow Marine Ltd. v. Washington Iron Works*, [1974] S.C.R. 1189.
172. *Donoghue v. Stevenson* *supra*, note 168.
173. *Ibid.*
174. *Phillips v. Ford Motor Co.*, [1971] 2 O.R. 637 at 653.
175. Fleming, *supra*, note 163, 473-74.
176. *Canada v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205. See also, for example, Hazardous Products Act, R.S.C. 1970, c. H-3.
177. *Buchan v. Ortho Pharmaceutical (Can.) Ltd.* (1984), 46 O.R. (2d) 113; aff'd (1986), 54 O.R. (2d) 92 (C.A.). Compliance with Food and Drugs Act, R.S.C. 1970, c. F-27, inadequate as to packaging inserts for birth control pills.
178. *Meilleur v. U.N.I.-Crete Canada Ltd.* (1985), 32 C.C.L.T. 126 (Ont. H.C.).
179. *Murphy v. Atlantic Speedy Propane Ltd.* (1979), 103 D.L.R. (3d) 545 (N.S.T.D.).
180. A.M. Linden, *Canadian Tort Law*, 3d ed. (Toronto: Butterworths, 1982), 549.
181. *Ho Lem v. Barotto Sports Ltd.*, [1976] 6 W.W.R. 430 (Alta. C.A.).
182. *Cominco Ltd. v. Westinghouse Canada Ltd.* (1981), 45 B.C.L.R. 26; revd on other grounds (1983), 45 B.C.L.R. 35 (B.C.C.A.).
183. *Davidson v. Connaught Laboratories* (1980), 14 C.C.L.T. 251 (Ont. H.C.).
184. *Lambert v. Lastoplex Chemicals Co.*, [1972] S.C.R. 569.
185. *Yachetti v. John Duff & Sons Ltd.*, [1942] O.R. 682 (H.C.).
186. *Buchan v. Ortho Pharmaceutical*, *supra*, note 177.
187. [1972] 3 All E.R. 1008.
188. [1988] 1 All E.R. 871.
189. *Snell v. Farrell* (1990), 72 D.L.R. (4th) 289; for a discussion of this case and the relevant Canadian law, see Klar, *supra*, note 155, 264-67.
190. *Swinton, supra*, note 45, 45, 66.
191. U.S. Congress, *supra*, note 3, 322. Much of the discussion of causation derives from this source.

192. Ibid.
193. For an example of the difficulty in establishing causation in the context of birth defects and infant vaccinations, see *Rothwell v. Raes* (1988), 66 O.R. (2d) 449, aff'd. by the Ont. C.A. in (1990), 2 O.R. (3d) 322.
194. S. Waddams, *Products Liability*, 2d ed. (Toronto: Carswell, 1980), 65.
195. Fleming, *supra*, note 163, 362.
196. Klar, *supra*, note 155, 320.
197. G.H.L. Friedman, *The Law of Torts in Canada* (Toronto: Carswell, 1989), 372.
198. In *Mathison v. Hofer*, [1984] 3 W.W.R. 343, 28 C.C.L.T. 196 (Man. Q.B.), the plaintiff suffered a severe depression as a result of an accident that led to the stillbirth of the fetus she was carrying. The plaintiff was awarded \$7 000.00 general damages to cover her pain and suffering and the loss of earnings she experienced on account of her depression.
199. *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229.
200. *Mathison v. Hofer*, *supra*, note 198.
201. *Goldsmith's Damages for Personal Injury and Death in Canada* (Toronto: Carswell, 1989), Reproductive Organs at T34.
202. *X v. Uron* (B.C., 1990) (ex rel. Messrs. MacIsaac & Clark) #404.
203. *McEachern v. B.P. Can. Ltd.* (Ont. 3 October 1973) (1973-77) #34.2.
204. Family Law Reform Act, R.S.O. 1980, c. 152, s. 69(3).
205. Fleming, *supra*, note 163, 622.
206. [1952] A.C. 716 (H.L.).
207. For a summary of damage awards for loss of consortium, see *Goldsmith's Damages for Personal Injury and Death*, *supra*, note 201, Consortium & Servitium T54-7.
208. In *Metilleur v. U.N.I.-Crete Canada Ltd.*, *supra*, note 178, the Ontario Supreme Court followed *Best v. Fox* to deny a wife damages for loss of consortium on account of injuries to her husband. Note, in this case, there was no mention of the fact that the action for loss of consortium was abolished.
209. Klar, *supra*, note 155, 175, footnote 162.
210. For a general discussion of punitive damages, see S. Waddams, *The Law of Damages* (Toronto: Canada Law Book, 1983), 562-92; E.A. Cherniak and J.R. Morse, "Aggravated, Punitive and Exemplary Damages in Canada," in *Torts in the 80s: Special Lectures of the Law Society of Upper Canada, 1983* (Don Mills: DeBoo, 1983), 151.
211. *Buchan v. Ortho Pharmaceutical*, *supra*, note 177.
212. In *MacDonald v. Sebastian* (1987), 42 C.C.L.T. 213 (N.S.T.D.), the conduct of the landlord in wilfully failing to disclose the high toxicity level of well water when he leased a house to the plaintiff, knowing that this would have deleterious effects on the plaintiff's health, was found to attract punitive damages.
213. D.B. Loewen, "Editorial Note: *McIntyre v. Atlantic Hardchrome Ltd.*," *Canadian Occupational Health and Safety Cases* 4 (1991): 175-76.

214. For the most complete and up-to-date discussion of civil responsibility and liability in Quebec, see J.-L. Baudouin, *La Responsabilité civile Délictuelle*, 3d ed. (Cowansville: Éditions Yvon Blais, 1990).
215. L. Perret, "The Evolution of the Law of 'Responsibility' in Quebec: The Civil Code and Special Statutes," in *Essays in the Civil Codes of Quebec and St. Lucia*, ed. R.A. Landry and E. Caparros (Ottawa: University of Ottawa Press, 1984).
216. K. Zweigert and H. Kotz, *An Introduction to Comparative Law*, vol. II, *The Institutions of Private Law* (Amsterdam: North-Holland, 1977), 288-89.
217. L. Baudouin, "Delicts Under the Quebec Civil Code," in *Canadian Jurisprudence: The Civil Law and Common Law in Canada*, ed. E. McWhinney (Toronto: Carswell, 1959), 169-96.
218. W.C. J. Meredith, "Delicts and Quasi-Delicts: 1923-47," *Canadian Bar Review* 26 (1948), 96. This basic rule was affirmed by the Supreme Court of Canada in *Rubits v. Gray Rocks Inn Ltd.*, [1982] 1 S.C.R. 452, where Beetz J. stated that common law precedents are of no assistance in civil law except where the legal principles are the same, and, even then, the common law does not have binding effect as the two systems are separate and complete.
219. Castel, *supra*, note 153, 402.
220. P.-A. Crépeau, "Liability for Damage Caused by Things: From the Civil Law Point of View," *Canadian Bar Review* 40 (1962), 223.
221. G.V.V. Nicholls, *The Responsibility for Offences and Quasi-Offences Under the Law of Québec* (Toronto: Carswell, 1938), 144.
222. In *Canadian Pacific Railway Co. v. Chalifoux* (1888), 22 S.C.R. 721, the company was relieved of responsibility because it met the duty of care.
223. *McArthur v. Dominion Cartridge Co.*, [1905] A.C. 72, rev'd. (1901), 31 S.C.R. 392.
224. *Shawinigan Carbide Co. v. Doucet* (1909), 42 S.C.R. 281, aff'd. 18 Que. K.B. 271, which rev'd. 35 Que. S.C. 385.
225. *Quebec Railway, Light, Heat and Power Co. v. Vandry*, [1920] A.C. 662 at 676-77.
226. *City of Montreal v. Watt and Scott Ltd.*, [1922] A.C. 555.
227. *Perusse v. Stafford*, [1928] S.C.R. 416.
228. *Canadian Vickers Ltd. v. Smith*, [1923] S.C.R. 203.
229. Castel, *supra*, note 153, 506.
230. *R. v. Laperrrière, R. v. Dubeau*, [1946] S.C.R. 415 at 444.
231. Perret, *supra*, note 215, 253-54; C. Ferron, "Les clauses de non-responsabilité en responsabilité civile contractuelle et délictuelle," *Revue du Barreau* 44 (1984): 3-69.
232. Perret, *supra*, note 215, 249.
233. Meredith, *supra*, note 218, 101-103.
234. *Letang v. Ottawa Electric Railway Co.*, [1926] A.C. 725.

235. *Corriveau v. Pelletier*, [1981] C.A. 347; *Dugal v. Procureur général du Québec*, [1979] C.S. 617; J.E. 82-1169 (C.A.).
236. *Canadian Pacific Railway Co. v. Robinson* (1887), 14 S.C.R. 105.
237. Ison, *supra*, note 89, 163. The discussion of the bar to civil actions of employees under workers' compensation and the limited possibility of tort actions derives from Ison's text.
238. Enacted as Schedule B to the Canada Act 1982, (U.K.) 1982, c. 11.
239. [1989] 1 S.C.R. 922.
240. (1991), 111 A.R. 228 (Alta. C.A.).
241. *Ibid.*, 235.
242. *Decision No. 169* (1975), 2 W.C.R. 262 (B.C.).
243. *Decision No. 525* (March 1987), (Ont. W.C.A.T.).
244. Ison, *supra*, note 89, 166.
245. *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205 at 223.
246. Ison, *supra*, note 89, 302.
247. *Wright v. Brunntng* (1985), 46 Sask. R. 104 (Q.B.).
248. *McIntyre v. Atlantic Hardchrome Ltd.* (1991), 109 N.S.R. (2d) 309 (C.A.), rev'd. (1991), 102 N.S.R. (2d) 1.
249. *Fédération des Employées et Employés de Services Publics Inc. c. Béliveau St-Jacques*, [1991] R.J.Q. 279 (C.A.). In this case the employer failed to make any effort to put an end to the sexual harassment of the plaintiff.
250. *Supra*, note 178.
251. This was the conclusion reached in *Grimm v. Co-operative Fire and Casualty Co.; C.A.T.Q. v. Fuyarchuk* (1981), 50 N.S.R. (2d) 462 (T.D.). The *Grimm* decision was considered by a single judge of the Saskatchewan Supreme Court in *Cudmore v. Tabin* (1984), 32 Sask. R. 105 (Sask. Q.B.) and was expressly disagreed with. Steele J. of the Ontario Supreme Court adopted the reasons in *Cudmore*. The Court in *Meilleur* rejected this argument, stating that *Grimm* should not be followed as it was based on a misconception of the meaning of subrogation.
252. See *MacIntosh v. Gzowski* (1979), 27 O.R. (2d) 151 (Ont. C.A.) on the meaning of subrogation under the Ontario Workers' Compensation Act.
253. *Decision No. 229* (1986), 2 W.C.A.T.R. 118 (Ont. W.C.A.T.); *Decision No. 490/88* (1988), 9 W.C.A.T.R. 332 (Ont. W.C.A.T.).
254. *Re Butler Trucking and Brydges* (1984), 46 O.R. (2d) 686 (H.C.).
255. *Meyer and McDermott v. Waycon International Trucks Ltd.* (1988), 38 O.A.C. 398 (Ont. C.A.).
256. Ison, *supra*, note 89, 173.
257. See the examples discussed *supra* in Section D.2.4(d).
258. A. Bale, "The American Compensation Phenomenon," *International Journal of Health Services* 20 (1990): 253-75.
259. (1985), 50 O.R. (2d) 218.

260. *Ibid.*, 221. *Dehler v. Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748 at 757, also addresses the question of fetal rights and is consistent with the decision in *Seede*. In *Dehler* the Court held that:

While there can be no doubt that the law has long recognized fetal life and has accorded the fetus various rights, those rights have always been held contingent upon a legal personality being acquired by the fetus upon its subsequent birth alive and, until then, a fetus is not recognized as included within the legal concept of "persons."

In *Matheson v. Hofer*, *supra*, note 198, the Manitoba Queen's Bench dismissed a claim for a death benefit under an insurance policy payable in respect of a insured whose child was stillborn as a result of an accident. Responding to the plaintiff's argument, the Court quoted *Seede*:

[it] is appealing in that it appears harsh that there be a right to claim compensation for loss of guidance, care and companionship with respect to a child that might have been born alive but died immediately after birth but not where a child *en ventre sa mère* had gone full term but was still-born. However, at times the law has sharp edges. (*supra*, note 259, 222-23)

- 261. [1989] 2 S.C.R. 530.
- 262. *Ibid.*, 560. See also R.P. Kouri, "Reflexions sur la statut juridique du foetus," *Revue juridique Thémis* 15 (1980-81): 193-200, which was referred to by the Court.
- 263. U.S. Congress, *supra*, note 3, 311; T.J. Scofield, "Recovery for Tortious Death of the Unborn," *South Carolina Law Review* 33 (1982): 797-817.
- 264. [1933] 4 D.L.R. 337 (S.C.C.).
- 265. Moreover, this position was subsequently affirmed by the Court in *Tremblay v. Datgle*, *supra*, note 261.
- 266. (1973), 40 D.L.R. (3d) 666 (Ont. C.A.).
- 267. *Duval v. Seguin*, [1972] 2 O.R. 686 at 701 (Ont. H.C.). Katherine Swinton does not interpret *Duval* as establishing a duty of care to the child *in utero*. She states that it is important to note that in *Duval* "the court did not expressly recognize a duty of care to the foetus; instead, it held that a cause of action for pre-natal injury was complete at birth, when the injuries were suffered." Swinton, *supra*, note 45, 65.
- 268. Family Law Act, R.S.O. 1990, c. F.3, s. 66.
- 269. U.S. Congress, *supra*, note 3, 310-11.
- 270. Swinton, *supra*, note 45, 65, referring to B.M. Dickens, *Medico-Legal Aspects of Family Law* (Toronto: Butterworths, 1979), 63, 88.
- 271. In *Jorgensen v. Meade Johnson Laboratories*, 483 F.2d 237 (U.S.C.A. 10th Cir.) (1973), a claim for damages caused by birth control pills taken before conception was allowed, while in *Renslow v. Mennonite Hospital* 351 N.E. 2d 870 (Ill. C.A.) (1976), a child sued successfully for damages because the mother had been given an improper blood transfusion eight years before the child's birth.
- 272. A. Samuels, "Injuries to Unborn Children," *Alberta Law Review* 12 (1974), 267.
- 273. Family Law Act, *supra*, note 268, s. 66.

274. Samuels, *supra*, note 272, 267.
275. Swinton, *supra*, note 45, 66.
276. K. Messing, *Occupational Safety and Health Concerns of Canadian Women: A Background Paper*, study prepared for Women's Bureau, Labour Canada (Ottawa: Minister of Supply and Services Canada, 1991), 25.
277. A.D. Bloom, ed., *Guidelines for Studies of Human Populations Exposed to Mutagenic and Reproductive Hazards* (White Plains: March of Dimes Birth Defects Foundation, 1981), 47, Table 1.
278. Messing, *supra*, note 276, 25-26.
279. *Ibid.*, 26.
280. S.G. Selevan and G.K. Lemasters, "The Dose-Response Fallacy in Human Reproductive Studies of Toxic Exposures," *Journal of Occupational Medicine* 29 (1987): 451-54.
281. Messing, *supra*, note 276, 26.
282. D.L. Kirp, "The Pitfalls of 'Fetal Protection,'" *Society* 28 (March-April 1991), 74.
283. Swinton, *supra*, note 45, 65.
284. Canada, Labour Canada, Women's Bureau, *Annotated Bibliography on Reproductive Hazards in the Workplace in Canada* (Ottawa: Minister of Supply and Services Canada, 1988), 57.
285. See the discussion and citations in the section on Occupational Health and Safety Legislation at C. 1.3.2(c).
286. Ian Hunter, "Human Rights Legislation in Canada: Its Origin, Development and Interpretation," *University of Western Ontario Law Review* 15 (1975-76): 21-58.
287. See K.E. Swinton and K.P. Swan, "The Interaction Between Human Rights Legislation and Labour Law," in *Studies in Labour Law*, ed. K.P. Swan and K.E. Swinton (Toronto: Butterworths, 1983), 111.
288. In *Board of Governors of Seneca College of Applied Arts and Technology v. Bhadauria* (1981), 124 D.L.R. (3d) 193, the Supreme Court of Canada held that the existence of human rights codes not only forecloses civil actions based directly on a breach of the codes, but also excludes any common law action based on the invocation of the public policy expressed in human rights legislation.
289. Chenier, *supra*, note 25, and Levitsky, *supra*, note 25.
290. One survey conducted in the United States in the mid-1980s indicates that at least 15 of the "Fortune 500," including Exxon, General Motors, Du Pont, BF Goodrich, and Olin, have adopted policies excluding women from jobs considered to be fetal hazards. L.J. Raines and S.P. Push, "Protecting Pregnant Workers," *Harvard Business Review* (May-June 1986): 26.
291. Men constitute 87.2 percent of the labour force in non-agricultural primary sector, 70.5 percent in manufacturing, and 90.6 percent in construction, whereas women constitute 60.6 percent of the labour force in finance, insurance, and real estate and 62.4 percent in service. In terms of occupations, women comprise 80.1 percent of the labour force in medicine and health, 79.9 percent in clerical, and 61.9 percent in teaching. Canada, Labour Canada, Women's Bureau, *Women in the Labour Force, 1990-91* (Ottawa: Minister of Supply and Services Canada, 1990), 16, 17.

292. In 1988, women employed full time, full year earned 65.3 percent of the income of their male counterparts. The situation is even worse for women employed in more precarious forms of employment. *Ibid.*, 41.
293. For a good overview of the range of explanations offered for sex segregation in the labour market, see P. Armstrong and H. Armstrong, *The Double Ghetto: Canadian Women and Their Segregated Work*, rev. ed. (Toronto: McClelland and Stewart, 1984), chaps. 4, 5, and 6.
294. Swinton, *supra*, note 45, 47.
295. The Office of Technology Assessment of the U.S. Congress states that numerous hospitals are reported to exclude fertile and/or pregnant women from some jobs; see U.S. Congress, *supra*, note 3, 235. However, according to a study cited by Levitsky, 17 percent of married working mothers work in jobs that may involve exposure to teratogens (agents that can cause birth defects), and that most of these jobs are traditionally female-dominated. Levitsky, *supra*, note 25, 488, 490.
296. This was the case when the Atomic Energy Control Board proposed to include nuclear medicine and related workers under the definition of Atomic Radiation Workers (ARWs). Arguing that they could not afford to designate a large number of employees as ARWs, hospitals concerned about potential liability for injury to a fetus proposed waivers as a solution. N.M. Chenier, *Protecting Women: Some Aspects of the Debate over Minting, Night Work and Atomic Radiation*, report prepared for Women's Bureau, Labour Canada (Ottawa: Minister of Supply and Services Canada, 1986).
297. Swinton, *supra*, note 45, 49.
298. Rioux, *supra*, note 10.
299. G. Atherley, "Human Rights Versus Occupational Medicine," *International Journal of Health Services* 13 (1983): 265-75.
300. For a detailed discussion of the legislation and procedures in each jurisdiction, see W.S. Tarnopolsky and W.F. Pentney, *Discrimination and the Law: Including Equality Rights Under the Charter* (Don Mills: DeBoo, 1985) (7th Cum. Suppl. 1991).
301. E. Hore, "Caught in the Act," *Saturday Night* (September 1989): 25.
302. Ontario Advisory Council, *supra*, note 75, 107.
303. Unreported decision of the Canadian Human Rights Tribunal, 21 March 1985.
304. *Wiens v. Inco*, *supra*, note 9; *Nguyen v. Pacific Building Maintenance Ltd.* (1991), 91 C.L.L.C. 17,025 (Sask. H.R. Bd. Inq.) (Katzman).
305. For a summary of this case, see S. M'Gonigle, *Pregnancy and Childbirth Discrimination: Health and Safety Hazards* (Ottawa: Canadian Human Rights Commission, Policy and Research Branch, 1985), 12.
306. *Re General Motors of Canada Ltd. and United Automobile Workers, Local 222* (1979), 24 L.A.C. (2d) 388 at 394 (Ont.) (Palmer).
307. Tarnopolsky and Pentney, *supra*, note 300, D-31 - D-34.
308. See, for example, Blakeslee, *supra*, note 73.
309. Canadian Human Rights Act, R.S.C. 1985, c. H-6, 3(2); Human Rights Act, R.S.N.B. 1973, c. H-11; Charter of Human Rights and Freedoms, R.S.Q. 1977,

- c. C-12, s. 10; Human Rights Code, R.S.O. 1990, c. H.19, s. 10(2); Human Rights Code, S.M. 1987-88, c. 45, s. 9; The Saskatchewan Human Rights Code, S.S. 1979, c. S-24.1, s. 2(0) ; Individual's Rights Protection Act, R.S.A. 1980, c. I-2, s. 38(2); Human Rights Act, S.Y. 1987, c. 3, s. 6.
310. The Human Rights Code, 1988, S.N. 1988, c. 62; Human Rights Act, R.S.P.E.I. 1988, c. H-12; Human Rights Act, S.N.S. 1969, c. 11, as amended; Human Rights Act, S.B.C. 1984, c. 22; Fair Practices Act, R.S.N.W.T. 1988, c. F-T.
311. *Bliss v. Attorney-General of Canada*, [1979] 1 S.C.R. 183.
312. *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219 at 1242.
313. In fact, this was the decision of at least one board of inquiry called on to decide whether the exclusion of women of childbearing potential was a form of sex discrimination. *Wiens v. Inco*, *supra*, note 9.
314. The Saskatchewan Human Rights Code, S.S. 1979, c. S-24.1, s. 2(d.1). In addition, a number of conditions are specifically enumerated under the broad definition of disability.
315. (1990), 12 C.H.R.R. D/19 (Ont. Bd. Inq.).
316. *Davison v. St. Paul Lutheran Home of Melville* (1991), 87 D.L.R. (4th) 94 (Sask. Q.B.), upholding the decision of the board of inquiry, (1991), 15 C.H.R.R. D/81 (Sask. Bd. Inq.) (Barber).
317. *Davison v. St. Paul Lutheran Home of Melville* (Sask. Bd. Inq.), *op. cit.*, D/82. Note, a board of inquiry in Ontario found that obesity did not constitute disability under the Ontario Human Rights Code, *Ontario (Human Rights Commission) v. Vogue Shoes* (1991), 14 C.H.R.R. D/425 (Ont. Bd. Inq.) (Pilkington). The board of inquiry held that obesity does not in itself amount to a physical disability within the meaning of the Code unless it is an ongoing condition, effectively beyond the individual's control, which limits or is perceived to limit his or her physical capabilities.
318. *Metropolitan General Hospital v. O.N.A.* (1987), 32 L.A.C. (3d) 10 (H.D. Brown); *Hamilton Civic Hospitals v. O.N.A.* (1988), 32 L.A.C. (3d) 284 (Saltman).
319. *Ontario (Human Rights Commission) and O'Malley v. Simpsons-Sears Limited*, [1985] 2 S.C.R. 536.
320. *Ibid.*, 551.
321. *Ontario Human Rights Commission and O'Malley*, *op. cit.*
322. *Ontario (Human Rights Commission) v. Etobicoke (Borough)*, [1982] 1 S.C.R. 202. In *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990], 2 S.C.R. 489, Wilson J. stated that *bona fide* occupational qualification and requirement "are equivalent and co-extensive terms."
323. *Ontario Human Rights Commission and O'Malley*, *supra*, note 319.
324. *Ontario (Human Rights Commission) v. Etobicoke (Borough)*, *supra*, note 322, 208.
325. In *Bhinder v. Canadian National Railway*, [1985] 2 S.C.R. 561, the Supreme Court of Canada upheld an employer safety policy requiring employees to wear hard hats even though this policy indirectly discriminated against the complainant on the grounds of his religious belief.

326. *Brossard (Ville) v. Québec (Commission des droits de la personne)*, [1988] 2 S.C.R. 279 at 311-12.
327. *Saskatchewan (Human Rights Commission) v. Saskatoon*, [1989] 2 S.C.R. 1297.
328. Human Rights Code, s. 23(2), enacted 1986, c. 64, s. 18(5).
329. *Central Alberta Dairy Pool, supra*, note 322.
330. In personal communication with the authors, a corporate employer, who wishes to remain anonymous, indicated that it currently excludes fertile women from a facility to protect fetuses from reproductive hazards.
331. E. Buss, "Getting Beyond Discrimination: A Regulatory Solution to the Problem of Fetal Hazards in the Workplace," *Yale Law Journal* 95 (1986), 579.
332. See references in Buss, *op. cit.*, 579.
333. *Ibid.*
334. K. Messing and D. Mergler, "Unions and Women's Occupational Health in Quebec," in *Women Challenging Unions*, ed. L. Briskin and P. McDermott (Toronto: University of Toronto Press).
335. *Supra*, note 9.
336. *Ibid.*, D/4815.
337. *Nguyen v. Pacific Building Maintenance Ltd.*, *supra*, note 304; Canadian Arsenal Plant, Canadian Human Rights Commission, Summary of Decisions taken at its meetings of 17 October and 21-22 November 1983, p. 7, discussed in L. Kaye, *Danger Keep Out! Exclusionary Hiring Practices by Employers: Reproductive Hazards at Work* (Ottawa: National Association of Women and the Law, 1985).
338. *Supra*, note 5.
339. 78 Stat. 241, as am. by 92 Stat. 2076, 42 U.S.C., s. 2000e(k).
340. *Johnson Controls, supra*, note 5, 1206.
341. *Ibid.*, 1207.
342. *Ibid.*, 1209. Note, however, that Blackmun J. went on to state that the Court was not dealing with a case in which costs would be so prohibitive as to threaten the survival of the employer's business. He simply made it clear that the incremental cost of hiring women cannot justify discriminating against them.
343. According to the board:
- First, with birth control, it is very unlikely she will become pregnant. Second, if that unlikely event occurs, it is unlikely that she will become exposed to nickel carbonyl gas before she becomes aware of her pregnancy and locates herself elsewhere. Third, in the unlikely event she becomes pregnant and is exposed to the gas, it is doubtful that there will be injury to the fetus (*supra*, note 9, D/4819).

In this case, there were strict engineering controls to keep the toxic gas out of the workplace. In fact, it was not the nickel carbonyl gas that was suspected of causing fetal damage, rather it was the antidote to this lethal gas that was suspected of having teratogenetic effects.

344. In distinguishing *Wiens* from *Bhinder*, the board of inquiry noted that (i) the cases dealt with different legislation (the Ontario Code in *Wiens*, the federal Act in *Bhinder*); (ii) that the Code in Ontario had been amended (although the amendment had not yet been proclaimed at the time of the complaint) to impose a duty to accommodate up to undue hardship in those cases in which the respondent had established a BFOQ; and (iii) that *Bhinder* dealt with indirect discrimination whereas *Wiens* dealt with direct discrimination (*supra*, note 9, D/4817).

345. Swinton, *supra*, note 7, *Central Alberta Dairy Pool*, *supra*, note 322. Note, however, the Ontario Human Rights Code now provides in s. 23(2) that an employer must both demonstrate a BFOQ and meet the duty to accommodate.

346. *Brossard*, *supra*, note 326, 311-12.

347. In this case, the employer introduced the exclusionary policy on the advice of its medical personnel. In seeking to justify its policy to the board, the employer relied on the testimony of its occupational health experts and a study warning of potential teratogenic effects in respect of rat and hamster fetuses. One of the experts called on behalf of the Ontario Human Rights Commission concluded that he was unconvinced by the existing studies that there was a specific risk of fetal damage through maternal exposure, and that both male and female workers were potentially at the same risk of exposure as far as a teratogenic basis is concerned. (*Wiens v. Inco*, *supra*, note 9, D/4800).

348. *Supra*, note 304.

349. The board found the employer liable for the actions of the supervisor in laying off the complainant.

350. A fuller discussion of this issue is provided below in the section on duty to accommodate.

351. See the digest of the EEOC's interim guidance in Bureau of National Affairs, "Equal Employment Opportunity Commission (EEOC) Withholds Approval of Broad Fetal Protection Plan," *United States Law Week* 58 (13 February 1990): 2461-62.

352. See, for example, the studies and cases cited and discussed in J.E. Bertin, "Reproductive Hazards in the Workplace," in *Reproductive Laws for the 1990s*, ed. S. Cohen and N. Taub (Clifton: Humana Press, 1988), 277, 278-81.

353. For example, see Olshan and Baird, *supra*, note 73, and Blakeslee, *supra*, note 73.

354. Bertin, *supra*, note 352, 212.

355. See *Krochak v. Hudson Bay Mining and Smelting*, *supra*, note 303, and *Re General Motors of Canada Ltd.*, *supra*, note 306, as discussed above.

356. See *Re General Motors of Canada Ltd.*, *supra*, note 306, where the arbitrator stated that the men's health and safety concerns regarding lead exposure could be addressed by the individual male worker exercising his right to refuse unsafe work.

357. D. Baker, "Alberta Human Rights Commission v. Central Alberta Dairy Pool," *McGill Law Journal* 36 (1991), 1450, 1451.

358. *Ontario Human Rights Commission and O'Malley*, *supra*, note 319. The Court did not precisely define the extent of the duty to accommodate because the employer did not adduce evidence of undue hardship.

359. *Bhinder v. Canadian National Railway*, *supra*, note 325.
360. Baker, *supra*, note 357, 1450.
361. Ontario, for example.
362. *Supra*, note 322.
363. *Ibid.*, 491.
364. In contrast, the minority of the Court held that the duty to accommodate was an integral part of the BFOQ defence.
365. *Brossard*, *supra*, note 326.
366. See, for example, *Wiens v. Inco*, *supra*, note 9 and *Krochak v. Hudson Bay Mining and Smelting*, *supra*, note 303. In the latter case, the parties agreed to a lead program and a guideline to physicians that encouraged female employees to notify their company physician if they intended to or had become pregnant. Once physicians were so notified, they were required to monitor the employee for lead exposure.

These cases, however, contrast with at least one other decision by a human rights adjudicator. In 1983, six women who handled toxic chemicals in the explosives area of a Canadian arsenals plant complained they had been laid off by the company after reporting in accordance with a requirement to report pregnancy at first awareness. They argued they should have been transferred from a toxic to a safe work area. The company argued there was no other available work at the time except office work, and the complainants did not have the skills to perform the available work. The complaint was dismissed on this ground (Canadian Human Rights Commission, Summary of Decisions at its meetings of 17 October and 21-22 November 1983, p. 7).

367. Guidelines for Assessing Accommodation Requirements for Persons with Disabilities under the Ontario Human Rights Code, 1981 as amended (1989).
368. *Ibid.*, 8.
369. Wiens, *supra*, note 9. However, the board noted that if the employer conforms to existing occupational health and safety regulations and guidelines, no prosecution will ensue where the employee contracts an industrial disease because of a special sensitivity.
370. (1991), 14 C.H.R.R. D/68 (Ont. Bd. Inq.) (Hovius).
371. It is interesting to note that the union obtained a provision in the collective agreement that entitled a pregnant employee, upon obtaining a doctor's certificate, to request a transfer and obligated the employer to make reasonable efforts to accommodate employees in such situations. As was noted in the decision, since the provision was in effect, two spray painters were accommodated under this provision by being moved out of the spray-paint room.
372. *Emrick Plastics v. Ontario (Human Rights Commission)* (1992), 90 D.L.R. (4th) 476.
373. *Ibid.*, 482.
374. *Metropolitan General Hospital*, *supra*, note 318; *Hamilton Civic Hospitals*, *supra*, note 318.

375. *Gohm v. Domtar Inc.* (1990) C.L.L.C. 17,027 (Pentney). The reasoning and result of the human rights board of inquiry were confirmed by a two to one majority of the Ontario Divisional Court; *Gohm v. Domtar Inc.* (1992), 89 D.L.R. (4th) 305.
376. Swinton, *supra*, note 7.
377. M'Gonigle, *supra*, note 305, 21. It should be noted that this research paper formed the basis for the commission's Policy on Pregnancy and Childbirth Discrimination as it relates to reproductive hazards.
378. Guidelines for Assessing Accommodation Requirements for Persons with Disabilities, *supra*, note 367.
379. Atherley, *supra*, note 299, 267.
380. Atherley, *supra*, note 299, 265; D. Nelkin and L. Tancredi, *Dangerous Diagnostics: The Social Power of Biological Information* (New York: Basic Books, 1989); Draper, *supra*, note 3.
381. G.R. LeClercq, "Workplace Reproductive Risk: Corporate Responsibilities," *Medical Bulletin* 43 (1)(1983), 35; N.M. Hanis and S.C. Phillips, "Considerations in the Development of a Reproductive Surveillance System for Exxon," *Medical Bulletin* 43 (1)(1983): 3-29.
382. Atherley, *supra*, note 299, 273.
383. K. Messing, J. Courville, and N. Vezina, "Minimizing Risks for Women in Non-Traditional Jobs," *New Solutions* 1 (4)(1991), 67.
384. Rioux, *supra*, note 10, 14 (emphasis in original).
385. Klitzman et al., *supra*, note 8, 13.
386. It is important to recognize that these figures minimize the significance of collective bargaining, for another 10 percent of the workforce is covered by collective agreements, although they are not union members.
387. A larger proportion of male paid workers (37.5 percent) than female paid workers (29.6 percent) were unionized in 1987. In 1987, women accounted for 39.6 percent of total union membership. In 1987, the highest female unionization rates were found in public administration (61.8 percent) and transportation, communication, and other utilities (50.2 percent); the lowest rates were in trade (8.8 percent) and finance, insurance, and real estate (9.2 percent). Women accounted for only 19.4 percent of union membership in manufacturing. Labour Market Activity Survey, Statistics Canada, 1988.
388. Economic Council of Canada, *Good Jobs, Bad Jobs: Employment in the Service Economy* (Ottawa: Minister of Supply and Services Canada, 1990).
389. A.H. Cook, V.R. Lorwin, and A.K. Daniels, *The Most Difficult Revolution: Women and Trade Unions* (Ithaca: Cornell University Press, 1992), 239-42.
390. See H.W. Arthurs et al., *Labour Law and Industrial Relations in Canada*, 3d ed. (Scarborough: Butterworths, 1988), 114.
391. E. Tucker, "The Law of Employers' Liability in Ontario 1861-1900: The Search for a Theory," *Osgoode Hall Law Journal* 22 (1984): 213-80.
392. *Wilson v. Tyneside Window Cleaning*, [1958] 2 Q.B. 110 (C.A.); *Wilsons & Clyde Coal v. English*, [1938] A.C. 57 (H.L.); *Marshment v. Borgstrom*, [1942] S.C.R. 374.

393. The common law barriers to a worker successfully suing his or her employer in tort for negligence resulting in injury were repealed by workers' compensation legislation.
394. For a discussion of maternity leave, see J. Fudge, *Labour Law's Little Sister: The Employment Standards Act and the Feminization of Labour* (Ottawa: Canadian Centre for Policy Alternatives, 1991), 49-59.
395. Employment Standards Act, S.B.C. 1980, c. 10, s. 52.
396. Labour Standards Act, S.Q. 1979, c. N-1.1, s. 81.7(2).
397. Section 88.1.
398. *Re Sunnystide Home for the Aged and London and District Service Workers' Union, Local 220* (1985), 21 L.A.C. (3d) 85 (Ont.) (Picher).
399. Swinton and Swan, *supra*, note 287, 124, referring to *McLeod v. Egan*, [1975] 1 S.C.R. 517, where Laskin C.J. stated that an arbitrator must interpret relevant statutes where the statute prohibits something that the collective agreement allows.
400. See the cases cited in Brown and Beatty, *supra*, note 38, 5-21 - 22 and 6-59 - 60.
401. P.C. Weiler, "The Arbitrator, the Collective Agreement and the Law," *Osgoode Hall Law Journal* 10 (1972), 141, 144-45.
402. Labour Code, R.S.B.C. 1979, c. 212, s. 98(g), and Trade Union Act, S.N.S. 1972, c. 19, s. 41(1)(e), which grant arbitrators authority to apply and enforce other labour and related statutes.
403. Swinton and Swan, *supra*, note 287, 14.
404. *Re General Motors of Canada*, *supra*, note 306. See Swinton, *supra*, note 45, 60-71, for a discussion of the General Motors case and its implications.
405. *Re General Motors of Canada*, *supra*, note 306, 394. The arbitrator left open the possibility that men could refuse to work in the battery shop on the grounds that it was unsafe.
406. Levitsky, *supra*, note 25, 494.
407. *Re Health Labour Relations Association of British Columbia (Surrey Memorial Hospital) and Hospital Employees' Union, Local 180* (1985), 29 L.A.C. (3d) 421 (B.C.) (Larson); *Re Pacific Press and Vancouver/New Westminster Newspaper Guild, Local 115* (1984), 14 L.A.C. (3d) 79 (B.C.) (Somjen).
408. Swinton, *supra*, note 45, 68.
409. Ibid.
410. S.J. Greckol, "Gender Issues in Arbitration: The Employee's Perspective," *Labour Arbitration Yearbook* 1 (1991), 153.
411. *Re Fritze and Board of Education of the County of Red Deer* (1984), 19 L.A.C. (3d) 353 (Alta.) (Elliot).
412. *Metropolitan General Hospital*, *supra*, note 318; *Hamilton Civic Hospitals*, *supra*, note 318.
413. L.S. Bacow, *Bargaining for Job Safety and Health* (Cambridge: MIT Press, 1980).

414. For an analysis of the shortcomings in employment standards legislation, see Fudge, *supra*, note 392.
415. Cook et al., *supra*, note 389, 223.
416. This broader approach is common in Scandinavian countries. For example, see B. Gustavsen and G. Hunnius, *New Patterns of Work Reform: The Case of Norway* (Oslo: Universitetsforlaget, 1981), and J.V. Johnson and G. Johansson, eds., *The Psychosocial Work Environment: Work Organization, Democratization and Health: Essays in Memory of Bertil Gardell* (Amityville: Baywood, 1991).
417. For example, see Mamelle et al., *supra*, note 13; Saurel-Cubizolles and Kaminski, *supra*, note 13; and Goulet and Thériault, *supra*, note 13.
418. R. Sass, "What's in a Name? The Occupational Hygienist's Problem with Threshold Limit Values," *American Journal of Industrial Medicine* 14 (1988): 355-63.
419. For a more detailed discussion, see E. Tucker, "Worker Participation in Health and Safety Regulation: Lessons from Sweden," *Studies in Political Economy* 37 (1992): 95-127.
420. For example, see M.S. Lewis-Beck and J.R. Alford, "Can Government Regulate Safety: The Coal Mine Example," *American Political Science Review* 74 (1980): 745-56.
421. *R. v. Windsor Board of Education* (1983), 12 C.E.L.R. 11 (Ont. Prov. Ct.).
422. For example, see *R. v. Cancoil Thermal Co.* (1986), 14 O.A.C. 225 (Ont. C.A.).
423. *R. v. Wholesale Travel Group Inc.* (1991), 84 D.L.R. (4th) 161 (S.C.C.), and *R. v. Ellts Don Ltd.*, [1992] 1 S.C.R. 840, rev'd. (1991), 76 D.L.R. (4th) 347 (Ont. C.A.).
424. For example, see *R. v. Rio Algom Limited* (1990), 1 C.O.H.S.C. 1, 46 C.C.C. (3d) 248 (Ont. C.A.).
425. *R. v. Cotton Felts Ltd.* (1982), 2 C.C.C. (3d) 287 (Ont. C.A.).
426. "Paving Firm Fined \$100,000 After Worker Hurt," *Toronto Star* (17 November 1991): A17; "Firm Fined \$75,000 After Worker Killed," *Toronto Star* (20 January 1992): C8; "Hydro Fined \$200,000 over Fatal Accident," *Toronto Star* (12 May 1992): A5; and "Bankrupt Firm Hit with \$400,000 Fine," *Windsor Star* (13 February 1992): A3.
427. For a discussion, see H.J. Glasbeek and S. Rowland, "Are Injuring and Killing at Work Crimes?" *Osgoode Hall Law Journal* 17 (1979): 507-94; and M.B. Bixby, "Workplace Homicide: Trends, Issues and Policy," *Oregon Law Review* 70 (1991): 333-79.
428. The pioneering work in this area is by Professor Ison. See his *The Forensic Lottery: A Critique on Tort Liability as a System of Personal Injury Compensation* (London: Staples Press, 1967); see also Tyson, *supra*, note 161, 425.

Bibliography

Books, Articles, Reports

Alberta. Alberta Occupational Health and Safety. *Medical Guidelines*, MSB/36 (June 1988), MSB/38 (June 1988), and MSB-06 (January 1992). Edmonton.

- Alberta. Workers' Compensation Board. *Claims Department Manual*. Edmonton.
- American Conference of Governmental Industrial Hygienists (ACGIH). *Documentation of the Threshold Limit Values and Biological Exposure Indices*. 6th ed. Cincinnati: ACGIH, 1991.
- Armstrong, B.G., A.D. Nolin, and A.D. McDonald. "Work in Pregnancy and Birth Weight for Gestational Age." *British Journal of Industrial Medicine* 46 (1989): 196-99.
- Armstrong, P., and H. Armstrong. *The Double Ghetto: Canadian Women and Their Segregated Work*. Rev. ed. Toronto: McClelland and Stewart, 1993.
- Arthurs, H.W., et al. *Labour Law and Industrial Relations in Canada*. 3d ed. Toronto: Butterworths, 1988.
- Atherley, G. "Human Rights Versus Occupational Medicine." *International Journal of Health Services* 13 (1983): 265-75.
- Atiyah, P.S. "Accident Prevention and Variable Premium Rates for Work-Connected Accidents." *Industrial Law Journal* 4 (1975): 1-11; 89-105.
- . "No-Fault Compensation: A Question That Will Not Go Away." *Insurance Law Journal* 694 (1980): 625-40.
- Axelsson, G., R. Rylander, and I. Molin. "Outcome of Pregnancy in Relation to Irregular and Inconvenient Work Schedules." *British Journal of Industrial Medicine* 46 (1989): 393-98.
- Bacow, L.S. *Bargaining for Job Safety and Health*. Cambridge: MIT Press, 1980.
- Baker, D. "Alberta Human Rights Commission v. Central Alberta Dairy Pool." *McGill Law Journal* 36 (1991): 1450-71.
- Bale, A. "The American Compensation Phenomenon." *International Journal of Health Services* 20 (1990): 253-75.
- "Bankrupt Firm Hit with \$400,000 Fine." *Windsor Star* (13 February 1992): A3.
- Barth, P.S., and A. Hunt. *Workers' Compensation and Work-Related Illnesses and Diseases*. Cambridge: MIT Press, 1980.
- Baudoin, L. "Delicts Under the Quebec Civil Code." In *Canadian Jurisprudence: The Civil Law and Common Law in Canada*, ed. E. McWhinney. Toronto: Carswell, 1958.
- Baudouin, J.-L. *La Responsabilité civile délictuelle*. 3d ed. Cowansville: Éditions Yvon Blais, 1990.
- Bélanger, S. "Le Retrait préventif de la travailleuse enceinte." *Canadian Journal of Women and the Law* 1 (1986): 498-504.
- Bertin, J.E. "Reproductive Hazards in the Workplace." In *Reproductive Laws for the 1990s*, ed. S. Cohen and N. Taub. Clifton: Humana Press, 1988.
- Bixby, M.B. "Workplace Homicide: Trends, Issues and Policy." *Oregon Law Review* 70 (1991): 333-79.
- Blakeslee, S. "Research on Birth Defects Shifts to Flaws in Sperm." *New York Times* (1 January 1991): A1.
- Bloom, A.D., ed. *Guidelines for Studies of Human Populations Exposed to Mutagenic and Reproductive Hazards*. White Plains: March of Dimes Birth Defects Foundation, 1981.

- Braithwaite, J. *To Punish or Persuade: Enforcement of Coal Mine Safety*. Albany: State University of New York Press, 1985.
- Brandt-Rauf, P.W., and S.I. Brandt-Rauf. "Ethical Aspects of Reproductive Health in the Workplace." *Occupational Medicine* 1 (1986): 509-515.
- Brown, D.J.M., and D.M. Beatty. *Canadian Labour Arbitration*. 3d ed. Aurora: Canada Law Book, 1991.
- Brown, R.M. "Canadian Occupational Health and Safety Legislation." *Osgoode Hall Law Journal* 20 (1982): 90-118.
- . "The Right to Refuse Unsafe Work." *University of British Columbia Law Review* 17 (1983): 1-34.
- Brown, R.M., and M. Rankin. "Persuasion, Penalties and Prosecution: Administrative v. Criminal Sanctions." In *Securing Compliance: Seven Case Studies*, ed. M.L. Friedland. Toronto: University of Toronto Press, 1990.
- Bureau of National Affairs. "Equal Employment Opportunity Commission (EEOC) Withholds Approval of Broad Fetal Protection Plan." *United States Law Week* 58 (13 February 1990): 2461-62.
- Buss, E. "Getting Beyond Discrimination: A Regulatory Solution to the Problem of Fetal Hazards in the Workplace." *Yale Law Journal* 95 (1986): 577-98.
- Canada. Economic Council of Canada. *Good Jobs, Bad Jobs: Employment in the Service Economy*. Ottawa: Minister of Supply and Services Canada, 1990.
- Canada. Labour Canada. *Employee Injuries and Occupational Illnesses*. Ottawa: 1990.
- Canada. Labour Canada. Women's Bureau. *Annotated Bibliography on Reproductive Hazards in the Workplace in Canada*. Ottawa: Minister of Supply and Services Canada, 1988.
- Canada. Labour Canada. Women's Bureau. *Women in the Labour Force, 1990-91*. Ottawa: Minister of Supply and Services Canada, 1990.
- Canada. Statistics Canada. *Work Injuries 1988-90*. Ottawa: 1992.
- Castel, J.-G. *The Civil Law System of the Province of Quebec: Notes, Cases, and Materials*. Toronto: Butterworths, 1962.
- Castleman, B.I., and G.E. Ziem. "Corporate Influence on Threshold Limit Values." *American Journal of Industrial Medicine* 13 (1988): 531-59.
- Chelius, J.R. "The Influence of Workers' Compensation on Safety Incentives." *Industrial and Labor Relations Review* 35 (1982): 235-42.
- Chelius, J.R., and R.S. Smith. "Experience-Rating and Injury Prevention." In *Safety and the Work Force: Incentives and Disincentives in Workers' Compensation*, ed. J.D. Worrall. Ithaca: ILR Press, 1983.
- Chenier, N.M. *Protecting Women: Some Aspects of the Debate over Mining, Night Work and Atomic Radiation*. Report prepared for Women's Bureau, Labour Canada. Ottawa: Minister of Supply and Services, 1986.
- . *Reproductive Hazards at Work: Men, Women and the Fertility Gamble*. Ottawa: Canadian Advisory Council on the Status of Women, 1982.
- . *The Selective Protection of Canadian Working Women*. Ottawa: Labour Canada, Women's Bureau, 1989.

- Cherniak, E.A., and J.R. Morse. "Aggravated, Punitive and Exemplary Damages in Canada." In *Torts in the 80s: Special Lectures of the Law Society of Upper Canada*, 1983. Don Mills: DeBoo, 1983.
- Cherry, N. "Physical Demands of Work and Health Complaints Among Women Working Late in Pregnancy." *Ergonomics* 30 (1987): 689-701.
- Cohen, S., and N. Taub. *Reproductive Laws for the 1990s*. Clifton: Humana Press, 1988.
- Cook, A.H., V.R. Lorwin, and A.K. Daniels. *The Most Difficult Revolution: Women and Trade Unions*. Ithaca: Cornell University Press, 1992.
- Crépeau, P.-A. "Liability for Damage Caused by Things: From the Civil Law Point of View." *Canadian Bar Review* 40 (1962): 222-54.
- Dee, G., N. McCombie, and G. Newhouse. *Workers' Compensation in Ontario*. Toronto: Butterworths, 1987.
- Derstine, D., and S. Nathu. "Workers' Compensation in Ontario: A Decade of Reform." *University of Toronto Faculty Law Review* 48 (1990): 22-47.
- Dickens, B.M. *Medico-Legal Aspects of Family Law*. Toronto: Butterworths, 1979.
- Draper, E. *Risky Business: Genetic Testing and Exclusionary Practices in the Hazardous Workplace*. Cambridge: Cambridge University Press, 1991.
- Engelberg, A.L., ed. *Guides to the Evaluation of Permanent Impairment*. 3d ed. Chicago: American Medical Association, 1988.
- England, G., ed. *Essays in Labour Relations Law*. Don Mills: CCH Canadian, 1986.
- Faden, R.R., and T.L. Beauchamp. *A History and Theory of Informed Consent*. New York: Oxford University Press, 1986.
- Farquhar, A. "WCAT on the New Frontier — Stress and Occupational Disease." *Compensation Appeals Forum* 4 (1)(1989): 21-31.
- Ferron, C. "Les clauses de non-responsabilité en responsabilité civile contractuelle et délictuelle." *Revue du Barreau* 44 (1984): 3-69.
- "Firm Fined \$75,000 After Worker Killed." *Toronto Star* (20 January 1992): C8.
- Fleming, J.G. *The Law of Torts*. 7th ed. Sydney: Law Book, 1987.
- Fridman, G.H.L. *The Law of Torts in Canada*. Toronto: Carswell, 1989.
- Friedland, M.L., ed. *Securing Compliance: Seven Case Studies*. Toronto: University of Toronto Press, 1990.
- Fudge, J. *Labour Law's Little Sister: The Employment Standards Act and the Feminization of Labour*. Ottawa: Canadian Centre for Policy Alternatives, 1991.
- Glasbeek, H.J. "A Role for Criminal Sanctions in Occupational Health and Safety." In *New Developments in Employment Law* (Meredith Memorial Lectures 1988). Montreal: Éditions Yvon Blais, 1989.
- Glasbeek, H.J., and R. Hasson. "Fault — The Great Hoax." In *Studies in Canadian Tort Law*, ed. L.N. Klar. Toronto: Butterworths, 1977.
- Glasbeek, H.J., and S. Rowland. "Are Injuring and Killing at Work Crimes?" *Osgoode Hall Law Journal* 17 (1979): 507-94.
- Goldsmith's *Damages for Personal Injury and Death in Canada*. Toronto: Carswell, 1989.

- Goulet, L., and G. Thériault. "Association Between Spontaneous Abortion and Ergonomic Factors: A Literature Review of the Epidemiologic Evidence." *Scandinavian Journal of Work and Environmental Health* 13 (1987): 399-403.
- Greckol, S.J. "Gender Issues in Arbitration: The Employee's Perspective." *Labour Arbitration Yearbook* 1 (1991): 143-66.
- Gunningham, N. *Safeguarding the Worker: Job Hazards and the Role of the Law*. Sydney: Law Book, 1984.
- Gunningham, N., and C. Winder. "Protective Legislation and Discrimination in Employment in the Australian Lead Processing Industries: Implications for Future Nondiscriminatory Legislation." *Journal of Occupational Health and Safety — Australia and New Zealand* 4 (1988): 175-86.
- Gustavsen, B., and G. Hunnius. *New Patterns of Work Reform: The Case of Norway*. Oslo: Universitetsforlaget, 1981.
- Hanis, N.M., and S.C. Philips. "Considerations in the Development of a Reproductive Surveillance System for Exxon." *Medical Bulletin* 43 (1)(1983): 3-29.
- Homer, C.J., S.A. James, and E. Siegel. "Work-Related Psychosocial Stress and Risk of Preterm, Low Birthweight Delivery." *American Journal of Public Health* 80 (1990): 173-77.
- Hore, E. "Caught in the Act." *Saturday Night* (September 1989): 25.
- Hunter, I. "Human Rights Legislation in Canada: Its Origin, Development and Interpretation." *University of Western Ontario Law Review* 15 (1975-76): 21-58.
- "Hydro Fined \$200,000 over Fatal Accident." *Toronto Star* (12 May 1992): A5.
- Ison, T.G. "The Calculation of Periodic Payments for Permanent Disability." *Osgoode Hall Law Journal* 22 (1984): 735-52.
- . *Compensation for Industrial Disease Under the Workers' Compensation Act of Ontario*. Toronto: Industrial Disease Standards Panel, 1989.
- . *The Dimensions of Industrial Disease*. Research and Current Issues Series No. 35. Kingston: Queen's University, Industrial Relations Centre, 1978.
- . *The Forensic Lottery: A Critique on Tort Liability as a System of Personal Injury Compensation*. London: Staples Press, 1967.
- . "Human Disability and Personal Income." In *Studies in Canadian Tort Law*, ed. L.N. Klar. Toronto: Butterworths, 1977.
- . "The Politics of Reform in Personal Injury Compensation." *University of Toronto Law Journal* 27 (1977): 385-402.
- . "The Significance of Experience Rating." *Osgoode Hall Law Journal* 24 (1986): 723-42.
- . "The Uses and Limits of Sanctions in Industrial Health and Safety." *Workers' Compensation Reporter* 2 (1975-76): 203.
- . *Workers' Compensation in Canada*. 2d ed. Toronto: Butterworths, 1989.
- Johnson, J.V., and G. Johansson, eds. *The Psychosocial Work Environment: Work Organization, Democratization and Health: Essays in Memory of Bertil Gardell*. Amityville: Baywood, 1991.
- Kaye, L. *Danger Keep Out! Exclusionary Hiring Practices by Employers: Reproductive Hazards at Work*. Ottawa: National Association of Women and the Law, 1985.

- Keith, N.A. *Ontario Health and Safety Law: A Comprehensive Guide to the Statute, Case-Law, Policy and Procedures*. Aurora: Canada Law Book, 1991.
- Kirp, D.L. "The Pitfalls of 'Fetal Protection.'" *Society* 28 (March-April 1991): 70-76.
- Klar, L.N. *Tort Law*. Toronto: Carswell, 1991.
- , ed. *Studies in Canadian Tort Law*. Toronto: Butterworths, 1977.
- Klitzman, S., et al. "A Woman's Occupational Health Agenda for the 1990's." *New Solutions* 1 (1)(1990): 1.
- Kouri, R.P. "Reflexions sur le statut juridique du foetus." *Revue juridique Thémis* 15 (1980-81): 193-200.
- Law Reform Commission of Canada. *Workplace Pollution*. Working Paper 53. Ottawa: LRC, 1986.
- LeClercq, G.R. "Workplace Reproductive Risk: Corporate Responsibilities." *Medical Bulletin* 43 (1)(1983): 30-39.
- Leslie, G. "The Statutory Right to Refuse Unsafe Work: A Comparison of Saskatchewan, Ontario and the Federal Jurisdiction." *Saskatchewan Law Review* 46 (1981-82): 235-70.
- Levitsky, M. "Protecting Workers from Reproductive Hazards." *Canadian Journal of Women and the Law* 1 (1986): 488-97.
- Levy, J.Y. "A Study of the Acceptable Risk Policies to Regulate Occupational Exposures to Carcinogenic Substances in Canada and the United States: Does a Lifetime Risk of One Excess Cancer Death per Thousand Workers Constitute an Acceptable Level of Risk?" Ph.D. dissertation, Clark University, 1991.
- Lewis-Beck, M.S., and J.R. Alford. "Can Government Regulate Safety: The Coal Mine Example." *American Political Science Review* 74 (1980): 745-56.
- Lindbohm, M.-L., et al. "Magnetic Fields of Video Display Terminals and Spontaneous Abortion." *American Journal of Epidemiology* 136 (1992): 1 041-51.
- Linden, A.M. *Canadian Tort Law*. 3d ed. Toronto: Butterworths, 1982.
- Lippel, K. "Workers' Compensation and Psychological Stress Claims in North American Law: A Microcosmic Model of Systemic Discrimination." *International Journal of Law and Psychiatry* 12 (1989): 41-70.
- Loewen, D.B. "Editorial Note: *McIntyre v. Atlantic Hardchrome Ltd.*" *Canadian Occupational Health and Safety Cases* 4 (1991): 175-76.
- Lofgren, D.J. *Dangerous Premises: An Insider's View of OSHA Enforcement*. Ithaca: ILR Press, 1989.
- McDonald, A.D., et al. "Congenital Defects and Work in Pregnancy." *British Journal of Industrial Medicine* 45 (1988): 581-88.
- . "Fetal Death and Work in Pregnancy." *British Journal of Industrial Medicine* 45 (1988): 148-57.
- . "Occupation and Pregnancy Outcome." *British Journal of Industrial Medicine* 44 (1987): 521-26.
- . "Prematurity and Work in Pregnancy." *British Journal of Industrial Medicine* 45 (1988): 56-62.

- McGarity, T.O. "Substantive and Procedural Discretion in Administrative Resolutions of Science Policy Questions: Regulating Carcinogens in EPA and OSHA." *Georgetown Law Journal* 67 (1978-79): 729-810.
- M'Gonigle, S. *Pregnancy and Childbirth Discrimination Health and Safety Hazards*. Ottawa: Canadian Human Rights Commission, Policy and Research Branch, 1985.
- McKenzie, G.G., and J.I. Laskin. *Report on the Administration of the Occupational Health and Safety Act*. Vol. 1. Toronto: Ontario Ministry of Labour, 1987.
- Malenfant, R. "Evolution of the Participation of Women in the Workforce in Quebec." *Round Table* (1993 forthcoming).
- Mamelle, N., I. Bertucat, and F. Munoz. "Pregnant Women at Work: Rest Periods to Prevent Preterm Birth?" *Paediatric and Perinatal Epidemiology* 3 (1989): 19-28.
- "A Matter of WHMIS Enforcement." *At the Source* 10 (2)(1989-90): 8-10.
- Mendeloff, J. *Regulating Safety: An Economic and Political Analysis of Occupational Safety and Health Policy*. Cambridge: MIT Press, 1979.
- Meredith, W.C.J. "Delicts and Quasi-Delicts: 1923-47." *Canadian Bar Review* 26 (1948): 95-116.
- Messing, K. *Occupational Safety and Health Concerns of Canadian Women: A Background Paper*. Study prepared for Women's Bureau, Labour Canada. Ottawa: Minister of Supply and Services Canada, 1991.
- Messing, K., and D. Mergler. "Unions and Women's Occupational Health in Quebec." *Women Challenging Unions*, ed. L. Briskin and P. McDermott (Toronto: University of Toronto Press, 1993).
- Messing, K., J. Courville, and N. Vezina. "Minimizing Risks for Women in Non-Traditional Jobs." *New Solutions* 1 (4)(1991): 66-71.
- Nelkin, D., and L. Tancredi. *Dangerous Diagnostics: The Social Power of Biological Information*. New York: Basic Books, 1989.
- New Zealand. Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand. *Report*. 1967.
- Nicholls, G.V.V. *The Responsibility for Offences and Quasi-Offences Under the Law of Québec*. Toronto: Carswell, 1938.
- Olshan, A.F., K. Teschke, and P.A. Baird. "Paternal Occupation and Congenital Anomalies in Offspring." *American Journal of Industrial Medicine* 20 (1991): 447-75.
- Ontario. Advisory Council on Occupational Health and Occupational Safety (ACOHOS). *Annual Report*. Toronto: various years.
- Ontario. Ministry of Labour. *Occupational Health and Safety Facts and Figures 1990-1991*. Toronto: 1991.
- Ontario. Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario. *Report*. Toronto: Queen's Printer, 1984.
- Ontario. Workers' Compensation Board. *Discussion Paper: Work-Relatedness in the Workers' Compensation System*. Toronto: 1990.
- . *Operational Policy Manual*. Toronto.

- Ontario Public Service Employees' Union. "Submission of the Health and Safety Inspectors of the Ontario Public Service Employees Union to the Standing Committee on Resources Development Regarding An Act to Amend the Occupational Health and Safety Act and Workers' Compensation Act." Toronto: 16 February 1990.
- Papp, L. "Worker-Safety Groups Called Costly Failure." *Toronto Star* (12 July 1991): A12.
- "Paving Firm Fined \$100,000 After Worker Hurt." *Toronto Star* (17 November 1991): A17.
- Penney, J. "Negotiating Ontario Standards." *New Solutions* (Fall 1991): 9-14.
- Perret, L. "The Evolution of the Law of 'Responsibility' in Quebec: The Civil Code and Special Statutes." In *Essays in the Civil Codes of Quebec and St. Lucia*, ed. R.A. Landry and E. Caparros. Ottawa: University of Ottawa Press, 1984.
- Quebec. Commission de la santé et de la sécurité du travail. *Rapport annuel*. Quebec: CSST, 1989.
- Raines, L.J., and S.P. Push. "Protecting Pregnant Workers." *Harvard Business Review* (May-June 1986): 26.
- Renaud, M., and C. St-Jacques. "The Right to Refuse in Québec: Five-Year Evolution of a New Mode of Expressing Risk." *International Journal of Health Services* 18 (1988): 401-17.
- Rioux, M.H. "Safety and Risk." *Just Cause* 2 (1984): 13-15.
- Roach, S.A., and S.M. Rappaport. "But They Are Not Thresholds: A Critical Analysis of the Documentation of Threshold Limit Values." *American Journal of Industrial Medicine* 17 (1990): 727-53.
- Roberts, W. "Poison Playoff." *Now* (2-8 November 1989): 8.
- Rohan, P. "The Trend of Work Injuries in Canada." *Family Physician* 24 (1978): 576-82.
- Rosen, R. "What Feminist Victory in the Court." *New York Times* (1 April 1991): A17.
- Rosenberg, M.J., P.J. Feldblum, and E.G. Marshall. "Occupational Influences on Reproduction: A Review of Recent Literature." *Journal of Occupational Medicine* 29 (1987): 584-91.
- Salter, L., E. Levy, and W. Liess. *Mandated Science: Science and Scientists in the Making of Standards*. Dordrecht: Kluwer, 1988.
- Samuels, A. "Injuries to Unborn Children." *Alberta Law Review* 12 (1974): 266-270.
- Sass, R. "A Critique: Canadian Public Policy in Workplace Health and Safety." *New Solutions* 2 (Fall 1991): 39-46.
- . "What's in a Name? The Occupational Hygienist's Problem with Threshold Limit Values." *American Journal of Industrial Medicine* 14 (1988): 355-63.
- Saurel-Cubizolles, M.J., and M. Kaminski. "Pregnant Women's Working Conditions and Their Changes During Pregnancy: A National Study in France." *British Journal of Industrial Medicine* 44 (1987): 236-43.
- Schrecke, T. *The Pitfalls of Standards*. Hamilton: Canadian Centre for Occupational Health and Safety, 1986.

- Scofield, T.J. "Recovery for Tortious Death of the Unborn." *South Carolina Law Review* 33 (1982): 797-817.
- Selevan, S.G., and G.K. Lemasters. "The Dose-Response Fallacy in Human Reproductive Studies of Toxic Exposures." *Journal of Occupational Medicine* 29 (1987): 451-54.
- SPR Associates. "An Evaluation of Joint Health and Safety Committees in Ontario: As Based on Mail Surveys of Worker and Management Members of Joint Health and Safety Committees in Over 3,000 Industrial, Mining, Educational and Health Workplaces." In Ontario, Advisory Council on Occupational Health and Occupational Safety, *Eighth Annual Report*, vol. 2 (1986).
- Sugarman, S.D. "Doing Away with Tort Law." *California Law Review* 73 (1985): 555-664.
- Swan, K.P., and K.E. Swinton, eds. *Studies in Labour Law*. Toronto: Butterworths, 1983.
- Swinton, K. "Accommodating Women in the Workplace: Reproductive Hazards and Seniority Systems." *Canadian Labour Law Journal* 1 (1990): 125-39.
- . "Enforcement of Occupational Health and Safety Legislation: The Role of the Internal Responsibility System." In *Studies in Labour Law*, ed. K.P. Swan and K.E. Swinton. Toronto: Butterworths, 1983.
 - . "Regulating Reproductive Hazards in the Workplace: Balancing Equality and Health." *University of Toronto Law Journal* 33 (1983): 45-73.
- Swinton, K.E., and K.P. Swan. "The Interaction Between Human Rights Legislation and Labour Law." In *Studies in Labour Law*, ed. K.P. Swan and K.E. Swinton. Toronto: Butterworths, 1983.
- Tarnopolsky, W.S., and W.F. Pentney. *Discrimination and the Law: Including Equality Rights Under the Charter*. Don Mills: DeBoo, 1985. 7th Cumulative Supplement, 1991.
- Taskinen, H.K. "Effects of Parental Occupational Exposures on Spontaneous Abortion and Congenital Malformation." *Scandinavian Journal of Work and Environmental Health* 16 (1990): 297-314.
- Trudeau, G., and J.-P. Villagi. "Le Retrait préventif de la femme enceinte en vertu de la Loi sur la santé et la sécurité du travail: où en sommes-nous?" *Revue du Barreau* 46 (1986): 477-502.
- Tucker, E. *Administering Danger in the Workplace: The Law and Politics of Occupational Health and Safety Regulation in Ontario, 1850-1914*. Toronto: University of Toronto Press, 1990.
- . "The Determination of Occupational Health and Safety Standards in Ontario, 1860-1982: From the Market to Politics to ...?" *McGill Law Journal* 29 (1984): 260-311.
 - . "The Law of Employers' Liability in Ontario 1861-1900: The Search for a Theory." *Osgoode Hall Law Journal* 22 (1984): 213-80.
 - . "The Persistence of Market Regulation of Occupational Health and Safety: The Stillbirth of Voluntarism." In *Essays in Labour Relations Law*, ed. G. England. Don Mills: CCH Canadian, 1986.
 - . "Worker Participation in Health and Safety Regulation: Lessons from Sweden." *Studies in Political Economy* 37 (1992): 95-127.

- Tuohy, C. "Decision Trees and Political Thickets: An Approach to Analysing Regulatory Decision-Making in the Occupational Health Arena." *Law and Economics Workshop Series*, No. WSVI-15. Toronto: University of Toronto, Faculty of Law, 1984.
- . "Procedural Rationality and Regulatory Decision-Making: A Decision Framework Approach." *Law & Policy* 7 (1985): 354-73.
- Turcotte, G. "How Pregnant Workers See Their Work, Its Risks and the Right to Precautionary Leave in Quebec." *Women and Health* 18 (1992): 79-95.
- United States. Congress. Office of Technology Assessment. *Reproductive Health Hazards in the Workplace*. Washington, DC: U.S. Government Printing Office, 1985.
- Waddams, S. *The Law of Damages*. Toronto: Canada Law Book, 1983.
- . *Products Liability*. 2d ed. Toronto: Carswell, 1980.
- Walters, V. "State Mediation of Conflicts over Work Refusals: The Role of the Ontario Labour Relations Board." *International Journal of Health Services* 21 (1991): 717-29.
- Walters, V., and T. Haines. "Workers' Use and Knowledge of the 'Internal Responsibility System': Limits to Participation in Occupational Health and Safety." *Canadian Public Policy* 14 (1988): 411-23.
- Weiler, P.C. "The Arbitrator, the Collective Agreement and the Law." *Osgoode Hall Law Journal* 10 (1972): 141-53.
- . *Protecting the Worker from Disability: Challenges for the Eighties*. Toronto: Ontario Ministry of Labour, 1983.
- Williams, S. "The Right to Refuse." *Occupational Health & Safety Canada* 4 (January-February 1988): 20-27.
- Worrall, J.D., ed. *Safety and the Work Force: Incentives and Disincentives in Workers' Compensation*. Ithaca: ILR Press, 1983.
- Yassi, A. "Occupational Disease and Workers' Compensation in Ontario." Report prepared for Professor Paul C. Weiler in his study of Workers' Compensation in Ontario, n.d.
- Ziem, G.E., and B.I. Castleman. "Threshold Limit Values: Historical Perspectives and Current Practice." *Journal of Occupational Medicine* 31 (1989): 910-18.
- Zweigert, K., and H. Kotz. *An Introduction to Comparative Law*. Vol. II. *The Institutions of Private Law*. Amsterdam: North-Holland, 1977.

Cases

- Andrews v. Grand & Toy (Alberta) Ltd.*, [1978] 2 S.C.R. 229.
- Best v. Fox*, [1952] A.C. 716 (H.L.).
- Bhinder v. Canadian National Railway*, [1985] 2 S.C.R. 561.
- Bliss v. Attorney-General of Canada*, [1979] 1 S.C.R. 183.
- Board of Governors of Seneca College of Applied Arts and Technology v. Bhadauria* (1981), 124 D.L.R. (3d) 193 (S.C.C.).
- Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219.

- Brossard (Ville) v. Québec (Commission des droits de la personne)*, [1988] 2 S.C.R. 279.
- Buchan v. Ortho Pharmaceutical (Can.) Ltd.* (1984), 46 O.R. (2d) 113, aff'd. (1986), 54 O.R. (2d) 92 (C.A.).
- Budge v. Workers' Compensation Board (Alberta) (No. 2)* (1991), 111 A.R. 228 (Alta. C.A.).
- Canada v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205.
- Canadian Pacific Railway Co. v. Chalifoux* (1888), 22 S.C.R. 721.
- Canadian Pacific Railway Co. v. Robinson* (1887), 14 S.C.R. 105.
- Canadian Vickers Ltd. v. Smith*, [1923] S.C.R. 203.
- Cassan et al. v. Hudson Bay Mining and Smelting*. See *Krochak v. Hudson Bay Mining and Smelting*.
- Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 S.C.R. 489.
- City of Montreal v. Watt and Scott Ltd.*, [1922] A.C. 555.
- Cominco Ltd. v. Westinghouse Canada Ltd.* (1981), 45 B.C.L.R. 26, rev'd (1983), 45 B.C.L.R. 35 (B.C.C.A.).
- Cook v. Lewis*, [1951] S.C.R. 830.
- Evratre v. Ottawa (City)*, [1986] O.L.R.B. Rep. 798.
- Corriveau v. Pelletier*, [1981] C.A. 347.
- Cudmore v. Tabin* (1984), 32 Sask. R. 105 (Sask. Q.B.).
- Davidson v. Connaught Laboratories* (1980), 14 C.C.L.T. 251 (Ont. H.C.).
- Davison v. St. Paul Lutheran Home of Melville* (1991), 87 DLR (4th) 94 (Sask. Q.B.), affg. (1991), 15 C.H.R.R. D/81 (Sask. Bd. Inq.) (Barber).
- Decision No. 3* (1973), 1 W.C.R. 11 (B.C.).
- Decision No. 38* (1974), 1 W.C.R. 157 (B.C.).
- Decision No. 95* (1975), 2 W.C.R. 6 (B.C.).
- Decision No. 157* (1975), 2 W.C.R. 198 (B.C.).
- Decision No. 169* (1975), 2 W.C.R. 262 (B.C.).
- Decision No. 229* (1986), 2 W.C.A.T.R. 118 (Ont. W.C.A.T.).
- Decision No. 490/88 I* (1988), 9 W.C.A.T.R. 332 (Ont. W.C.A.T.).
- Decision No. 525* (March 1987), (Ont. W.C.A.T.).
- Decision No. 785/88* (10 April 1989), (Ont. W.C.A.T.).
- Decision No. 785/88RI* (1991), 19 W.C.A.T.R. 61 (Ont. W.C.A.T.).
- Decision No. 785/R* (1992), 21 W.C.A.T.R. 1 (Ont. W.C.A.T.).
- Decision No. 850* (1988), (Ont. W.C.A.T.).
- Decision No. 918* (1988), (Ont. W.C.A.T.).
- Dehler v. Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748.
- Donoghue v. Stevenson*, [1932] A.C. 562 (H.L.).

- Dugal v. Procureur général du Québec*, [1979] C.S. 617; J.E. 82-1169 (C.A.).
- Duval v. Seguin*, [1972] 2 O.R. 686 (Ont. H.C.), (1973), 40 D.L.R. (3d) 666 (Ont. C.A.).
- Emrick Plastics v. Ontario (Human Rights Commission)* (1992), 90 D.L.R. (4th) 476 (Ont. Div. Ct.) aff'g. *Heincke v. Brownell* (1991), 14 C.H.R.R. D/68 (Ont. Bd. Inq.) (Hovius).
- Fédération des Employées et Employés de Services Publics Inc. c. Béltveau St-Jacques*, [1991] R.J.Q. 279 (C.A.).
- Grimm v. Co-operative Fire and Casualty Co.; C.A.T.Q. v. Fuyarchuk* (1981), 50 N.S.R. (2d) 462 (T.D.).
- Hamilton Civic Hospitals v. O.N.A.* (1988), 32 L.A.C. (3d) 284 (Saltman).
- Ho Lem v. Barotto Sports Ltd.*, [1976] 6 W.W.R. 430 (Alta. C.A.).
- International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW v. Johnson Controls*, 111 S. Ct. 1196 (1991).
- Jorgensen v. Meade Johnson Laboratories*, 483 F.2d 237 (U.S.C.A. 10th Cir.) (1973).
- Krochak v. Hudson Bay Mining and Smelting*, unreported, Canadian Human Rights Tribunal, 21 March 1985.
- Lambert v. Lastoplex Chemicals Co.*, [1972] S.C.R. 569.
- Letang v. Ottawa Electric Railway Co.*, [1926] A.C. 725.
- Letwyn v. Versatile Farm Equipment Operations* (1991), C.E.S.H.G. par. 95,215 (Man. L.R.B.).
- MacDonald v. Sebastian* (1987), 42 C.C.L.T. 213 (N.S.T.D.).
- Marshment v. Borgstrom*, [1942] S.C.R. 374.
- Mathison v. Hofer*, [1984] 3 W.W.R. 343, (1984), 28 C.C.L.T. 196 (Man. Q.B.).
- McArthur v. Dominion Cartridge Co.*, [1905] A.C. 72, rev'g. (1901), 31 S.C.R. 392.
- McEachern v. B.P. Can. Ltd.* (Ont. 3 October 1973) (1973-77) #34.2.
- McGhee v. National Coal Board*, [1972] 3 All E.R. 1008.
- MacIntosh v. Gzowski* (1979), 27 O.R. (2d) 151 (Ont. C.A.).
- McIntyre v. Atlantic Hardchrome Ltd.* (1991), 109 N.S.R. (2d) 309 (C.A.), rev'g. (1991), 102 N.S.R. (2d) 1.
- McLeod v. Egan*, [1975] 1 S.C.R. 517.
- Meilleur v. U.N.I.-Crete Canada Ltd.* (1985), 32 C.C.L.T. 126 (Ont. H.C.).
- Metropolitan General Hospital v. O.N.A.* (1987), 32 L.A.C. (3d) 10 (H.D. Brown).
- Meyer and McDermott v. Waycon International Trucks Ltd.* (1988), 38 O.A.C. 398 (Ont. C.A.).
- Montreal Tramways v. Léveillé*, [1933] 4 D.L.R. 337 (S.C.C.).
- Murphy v. Atlantic Speedy Propane Ltd.* (1979), 103 D.L.R. (3d) 545 (N.S.T.D.).
- Nugent v. Bell Canada*, [1982] 1 C.L.R.B.R. 416.
- Ontario (Human Rights Commission) v. Etobicoke (Borough)*, [1982] 1 S.C.R. 202.

- Ontario (Human Rights Commission) v. Vogue Shoes* (1991), 14 C.H.R.R. D/425 (Ont. Bd. Inq.) (Pilkington).
- Ontario Human Rights Commission and O'Malley v. Simpsons-Sears Limited*, [1985] 2 S.C.R. 536.
- Ontario Public Service Employees' Union v. Ontario (Ministry of Labour)* (unreported decision of W.S. Melnyshyn, Director, Industrial Health and Safety Branch, 20 October 1982).
- Gohm v. Domtar Inc.* (1992), 89 D.L.R. (4th) 305, affg. *Gohm v. Domtar Inc.* (1990), C.L.L.C. 17,027 (Pentney).
- Outmette v. Lily Cups Ltd.* (1990), 12 C.H.R.R. D/19 (Ont. Bd. Inq.).
- Perusse v. Stafford*, [1928] S.C.R. 416.
- Pharand v. Inco Metals Co.*, [1980] 3 C.L.R.B.R. 194 (Ont.).
- Phillips v. Ford Motor Co.*, [1971] 2 O.R. 637.
- Nguyen v. Pacific Building Maintenance Ltd.* (1991), 91 C.L.L.C. 17,025 (Sask. H.R. Bd. Inq.) (Katzman).
- Quebec Railway, Light, Heat and Power Co. v. Vandry*, [1920] A.C. 662.
- R. v. Cancoil Thermal Co.* (1986), 14 O.A.C. 225 (Ont. C.A.).
- R. v. Cotton Felts Ltd.* (1982), 2 C.C.C. (3d) 287 (Ont. C.A.).
- R. v. Ellis-Don Ltd.*, [1992] 1 S.C.R. 840, rev'd. (1991), 76 D.L.R. (4th) 347 (Ont. C.A.).
- R. v. Laperrière, R. v. Dubeau*, [1946] S.C.R. 415.
- R. v. Rio Algom Ltd.* (1990), 1 C.O.H.S.C. 1, 46 C.C.C. (3d) 248 (Ont. C.A.).
- R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205.
- R. v. Wholesale Travel Group Inc.* (1991), 84 D.L.R. (4th) 161 (S.C.C.).
- R. v. Windsor Board of Education* (1983), 12 C.E.L.R. 11 (Ont. Prov. Ct.).
- Re Butler Trucking and Brydges* (1984), 46 O.R. (2d) 686 (H.C.).
- Re Evans and Workers' Compensation Board* (1982), 138 D.L.R. (3d) 346 (B.C.C.A.).
- Re Fritze and Board of Education of the County of Red Deer* (1984), 19 L.A.C. (3d) 353 (Alta.) (Elliot).
- Re General Motors of Canada Ltd. and United Automobile Workers, Local 222* (1979), 24 L.A.C. (2d) 388 (Ont.) (Palmer).
- Re Health Labour Relations Association of British Columbia (Surrey Memorial Hospital) and Hospital Employees' Union, Local 180* (1985), 29 L.A.C. (3d) 421 (B.C.) (Larson).
- Re Pacific Press and Vancouver/New Westminster Newspaper Guild, Local 115* (1984), 14 L.A.C. (3d) 79 (B.C.) (Somjen).
- Re Steel Co. of Canada Ltd. and United Automobile Workers, Local 1005* (1973), 4 L.A.C. (2d) 315 (Ont.) (Johnston).
- Re Sunnyside Home for the Aged and London and District Service Workers' Union, Local 220* (1985), 21 L.A.C. (3d) 85 (Ont.) (Picher).
- Reference re Workers' Compensation Act, 1983 (Nfld.)*, [1989] 1 S.C.R. 922.
- Renslow v. Mennonite Hospital*, 351 N.E. 2d 870 (Ill. C.A.) (1976).

- Rivtow Marine Ltd. v. Washington Iron Works*, [1974] S.C.R. 1189.
- Rothwell v. Raes* (1988), 66 O.R. (2d) 449, aff'd. (1990), 2 O.R. (3d) 322 (Ont. C.A.).
- Rubis v. Gray Rocks Inn Ltd.*, [1982] 1 S.C.R. 452.
- Saskatchewan (Human Rights Commission) v. Saskatoon*, [1989] 2 S.C.R. 1297.
- Seede v. Camco Inc.* (1985), 50 O.R. (2d) 218.
- Shawinigan Carbide Co. v. Doucet* (1909), 42 S.C.R. 281, aff'g. 18 Que. K.B. 271, which rev'd. 35 Que. S.C. 385.
- Sibley v. Atomic Energy Board of Canada* (1983), 3 C.L.R.B.R. (N.S.) 409.
- Snell v. Farrell* (1990), 72 D.L.R. (4th) 289.
- Tremblay v. Daigle*, [1989] 2 S.C.R. 530.
- Wiens v. Inco Metals Co.* (1988), 9 C.H.R.R. D/4795 (Ont.) (Cumming).
- Wilsher v. Essex Area Health Authority*, [1988] 1 All E.R. 871.
- Wilson v. Tyneside Window Cleaning*, [1958] 2 Q.B. 110 (C.A.).
- Wilsons & Clyde Coal v. English*, [1938] A.C. 57 (H.L.).
- Wright v. Brunning* (1985), 46 Sask. R. 104 (Q.B.).
- X v. Uron* (B.C., 1990) (ex rel. Messrs. MacIsaac & Clark) #404.
- Yachetti v. John Duff and Sons Ltd.*, [1942] O.R. 682 (H.C.).

Legislation

- An Act respecting Labour Standards, S.Q. 1979, c. N-1.1.
- An Act respecting Occupational Health and Safety, S.Q. 1979, c. 63.
- An Act respecting Occupational Health and Safety, S.Q. 1985, c. 6.
- Atomic Energy Control Regulations, SOR/74-334; SOR/85-335.
- Canada Occupational Safety and Health Regulations, SOR/86-304.
- Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.
- Canadian Environmental Protection Act, S.C. 1988, c. 22.
- Canadian Human Rights Act, R.S.C. 1985, c. H-6.
- Charter of Human Rights and Freedoms, R.S.Q. 1977, c. C-12.
- Code for Medical Surveillance for Lead, O. Reg. 536/81.
- Code for Medical Surveillance for Mercury, O. Reg. 141/82.
- Controlled Products Regulations, SOR/88-66.
- Employment Standards Act, S.B.C. 1980, c. 10.
- Fair Practices Act, R.S.N.W.T. 1988, c. F-2.
- Family Law Act, R.S.O. 1990, c. F.3.
- Family Law Reform Act, R.S.O. 1980, c. 152.
- Food and Drugs Act, R.S.C. 1970, c. F-27.
- Hazardous Products Act, R.S.C. 1970, c. H-3.

Human Rights Act, S.B.C. 1984, c. 22.

Human Rights Act, R.S.N.B. 1973, c. H-11.

Human Rights Act, S.N.S. 1969, c. 11, as amended.

Human Rights Act, R.S.P.E.I. 1988, c. H-12.

Human Rights Act, S.Y. 1987, c. 3.

Human Rights Code, S.M. 1987-88, c. 45.

The Human Rights Code, 1988, S.N. 1988, c. 62.

Human Rights Code, R.S.O. 1990, c. H.19.

Individual's Rights Protection Act, R.S.A. 1980, c. I-2.

Industrial Accidents Act, S.Q. 1985, c. 6.

Labour Code, R.S.B.C. 1979, c. 212.

Occupational Health and Safety Act, R.S.O. 1990, c. O.1.

Pregnancy Discrimination Act, 78 Stat. 241, as am. by 92 Stat. 2076, 42 U.S.C., s. 2000e(k).

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 141/82.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 146/87.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 176/86.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 536/81.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 654/85.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 654/86.

Regulations Made Under the Occupational Health and Safety Act, O. Reg. 732/84.

Regulations Made Under the Workmen's Compensation Act, R.R.O. 1980, Reg. 951.

The Saskatchewan Human Rights Code, S.S. 1979, c. S-24.1.

Trade Union Act, S.N.S. 1972, c. 19.

Workers' Compensation Act, R.S.O. 1990, c. W.11.

Workmen's Compensation Act, R.S.O. 1980, c. 539.



The Challenge of the New Reproductive Technologies to Family Law

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Executive Summary

This paper reviews the legal implications for children born as a result of assisted human reproduction (AHR). Artificial insemination, egg donation, and preconception arrangements challenge family law principles, especially with respect to the determination of who constitutes a family member. The various forms of AHR complicate the legal significance of parenthood by making it possible for more than two individuals to be involved in the procreative process. This raises concerns about the divisibility of the rights and obligations of parenthood. Virtually all aspects of family law are regulated by provincial legislatures; only the law regulating marriage and divorce is under federal jurisdiction.

The paper outlines much of the existing legislative framework in each province and examines judicial decisions where courts have applied the existing law to decisions related to new reproductive technologies. One of the basic principles of family law is the law of filiation, which regulates parent-child relations. However, the existing law, in most cases, does not accommodate the complications in the attribution of parenthood arising when a child is born as a result of AHR. The paper also reviews other adequacies and inadequacies of existing family law in

relation to AHR and discusses some of the related moral and social issues. The paper concludes by offering some regulatory choices.

Introduction

The Relevance and Importance of Family Law

The focus of this paper is on how the children born of assisted human reproduction (AHR) fit into our legally structured family, and what the implications of new reproductive technologies (NRTs) are in terms of our traditional approach to family law.

Our purpose is to point out the potential legal problems facing both the "would-be parents" of such children and those who participate in the process but do not wish to play a role in the life of the child. As our context is family law in Canada, we consider the relevant issues from the various provincial and territorial perspectives. We review pertinent legislation in each province and territory. This is important for two reasons: (1) one cannot make policy recommendations without accurate knowledge of the current state of the law, and (2) much of the academic literature commonly available in Canada emanates from the United States. The Americans have substantially different laws and an enormous amount of state-to-state diversity on these issues. They also have a significantly different constitutional backdrop, which has an effect on much of the debate. Although the issues that arise in the context of these new technologies certainly have global significance, Canadian policy makers and legislators need to know what the existing Canadian law states.

In our view, the issues raised in this paper are critical not only to the NRTs. Any decision or recommendation made will have an effect on related fields of the law. Reliance on AHR may magnify issues of parenting and the legal right to parent that are of importance to current "alternative family forms" (i.e., those that do not fit the nuclear family model with one mother and one father). Decisions made in the field of family law as a result of AHR will affect other types of family situations.

We hope that this document contributes to the debate on the NRTs. Our contention is that we must accommodate legally our new social and biological realities.

The critical, overarching question for legal policy is not *whether*, but *how* to [accommodate] the new developments. Among the most difficult specific issues is how to resolve competing claims to parenthood of children born through artificial reproductive techniques.¹

Anyone familiar with the area of family law will recognize immediately that the title of this paper reveals an extremely ambitious undertaking. It will also be clear to them that it would be an impossible task to canvass all the relevant issues in under 120 pages. Due to the sheer magnitude of the

subject and time constraints, there are many issues relating to family law and the NRTs that we have been unable to explore. The fact that a given issue has not been dealt with does not indicate that it is necessarily of less importance than those issues we do address. We have not tackled the area of successions law in particular — something clearly important to the rights and obligations of those involved in collaborative reproduction.² Other issues, such as custody disputes between a genetic/gestational mother (surrogate) and the child's natural father and the rights of same-sex couples to raise children in legally sanctioned families, require substantially more study than we were able to give them.

In order to provide a coherent backdrop for the creation of new policy in this area, it is important that such fundamental issues as the status of frozen gametes and embryos be decided. The categorization of human gametes and embryos as property, as potential human beings, or in any other way will have an effect on the way rights over them are formalized. This, in turn, will have an impact on issues relating to the right to terminate unilaterally, before implantation, on any obligations arising from the birth of a child, and on the very nature of the interests being protected. This subject requires substantial in-depth study and is outside the realm of this paper.

While this paper does raise a number of issues relating to genetic/gestational preconception arrangements, there is no analysis of the possible power imbalances in the context of such arrangements or of many other important aspects of that issue. Again, it is hoped that this paper will be read in conjunction with papers focussing on these other issues.

Given the nature of the Canadian federation, the first topic addressed in this section is the question of jurisdiction. It would be impossible to make recommendations on this subject without knowing which level of government has jurisdiction. In the next section we address the issue of family law and how it relates to AHR.

The following sections of the paper address the current family law regime in Canada. Within this section, we review some of the commentary on the adequacies and inadequacies of the existing law in relation to AHR. We then raise some of the ethical and social issues that must be grappled with before rendering a decision on the most appropriate policy in this area. Finally, before we conclude the paper, we briefly describe alternative regulatory approaches.

Jurisdiction

The Constitution Act, 1982 establishes the framework for the division of powers between provincial and federal jurisdictions. Although matters of family law are an area of concurrent jurisdiction, with the exception of the law regulating "marriage and divorce," virtually all aspects of family law are regulated by the provincial legislatures.³ Within the context of divorce,

the corollary issues of custody access and support are dealt with in the federal Divorce Act.

To the extent that issues arising from AHR relate to family law, they will usually fall within provincial jurisdiction.

What Is Family Law?

Family law is the structure that regulates the legal relations between individuals in the family. Family is defined in Black's Law Dictionary as a "group of persons consisting of parents and children; father, mother and their children; immediate kindred, constituting fundamental social unit in civilised society."⁴ This definition is restricted given the reality of our society today; however, it reflects a powerful symbolic image of what a family "should" be.

There is no single incontrovertible definition of the family.⁵ The Vanier Institute stated in its submission to the Royal Commission that there exists a multiplicity of family forms in Canada, including "two parent, lone parent, blended, cohabiting couples, multigenerational, childless, homosexual, and native patterns of kinship."⁶ It has been argued that there is a variety of determinants of the family in our society, of which law is but one, albeit a powerful one.⁷ The other determinants include custom, culture, subjective intention, and biology.

In practical terms, family law is a panoply of legislation and judicial principles underscored by public policy. By its very nature the current law of the family is restrictive: by defining the family as a (married) heterosexual couple and their biological children (if there are any), the law does not formally sanction many of the family structures noted by the Vanier Institute.

A definitional framework having been established for the family and the relations between individuals, the private sphere of the family is usually left to function without legal interference until an issue becomes contentious or until the interests of one of the members of the family are threatened.⁸

The effect of this is that the alternative forms of the family outlined by the Vanier Institute can function within our society relatively unfettered, and many of them are socially but not legally sanctioned. They are unfettered to the extent that they order their own relations and they opt out of the legal scheme. They may exercise rights that stem from their relationship in particular areas, such as insurance law in certain circumstances; however, they are precluded from enforcing purely family rights and obligations.

A significant problem arises when individuals who do not live in a legally sanctioned family form wish to be recognized as a family for the conferral of certain benefits (such as parental rights to two women in a lesbian relationship), or when an individual seeks to assert a right or enforce an obligation that he or she deems to be a "family" right or

obligation and the law fails to recognize it as such (i.e., in the case of the breakdown of a homosexual relationship where one party seeks to obtain support from the other). The decision not to give legal sanction to these alternative forms of the family is a question of public policy.

Recent developments in the law relating to equality based on sexual orientation have brought some of the legal problems facing gay men and lesbians to the attention of the public. The federal government is examining the extent to which this equality will be enshrined and in so doing will unquestionably address, if even indirectly, many of the family rights and obligations between same-sex couples that the Canadian judicial system will recognize.⁹

AHR raises significant social and legal problems that are not limited to the issues raised above.

Modern reproductive techniques subdivide what was previously unitary. Various stages of the biological process can now be severed, allowing specific impaired aspects of the procreative process to be replaced by workable substitutes. As a result, more than two persons can now be biologically involved in a given instance of reproduction. Furthermore, because processes that previously were bundled can now be separated, procreation can be depersonalized: biological reproduction can be separated from the social and physical context of interpersonal intimacy. Whenever subdivision occurs, choices emerge. Developments in reproductive technology have created new biological and social options that in turn challenge old assumptions and pose new dilemmas for legal doctrine and policy.¹⁰

AHR introduces challenges to the particular rules that comprise the family law framework. Traditionally, family law has said something about maternity, paternity, filiation, custody, access, and support. However, the social and biological reality upon which those traditional family law concepts have been structured has been radically changed by the new reproductive techniques. The question is whether the legal principles that stem from a different social and biological reality are still appropriate. The response to this question is a matter for serious consideration and requires an understanding of the way the law functions in relation to individuals affected by AHR.

This paper will outline the relevant existing legislative frameworks for issues of family law in Canada, examine judicial decisions where the courts have had to apply the existing law to new factual situations, and canvass the academic commentary. The ultimate purpose of the paper is to provide adequate information upon which legislative and policy decisions can be made.

Family Law and the New Reproductive Technologies

Artificial insemination (AI), egg donation, and preconception arrangements challenge family law principles, especially with respect to the

determination of who constitutes a family member. Historically, the family unit has been premised on the "traditional" family form existing as a result of a legally sanctioned marriage. The principles and definitions governing the law of filiation assume that reproduction occurs within either a marital relationship or a stable heterosexual relationship, and it usually perpetuates this bias. In addition, the rules of law reflect an assumption that reproduction occurs only through sexual intercourse, an assumption greatly challenged by the various forms of assisted reproduction.

The legislative schemes that regulate family law in the provinces have not responded to the complications posed by AHR, with the exception of Newfoundland, the Yukon, and Quebec, which have introduced legislation regarding the presumption of paternity of children born of artificial insemination by donor (AID).¹¹ Family law is developed according to public policy considerations and in response to social needs, the circumstances of which have been changing rapidly over the last generation. Statistics Canada published a report in April 1992 that demonstrated that the nature of our families is changing: "over all, marriage is now less prevalent, occurs later in life and often does not last long enough for couples to raise families."¹² There has been a significant increase in the divorce rate from a generation ago, and the rate of common-law marriages has risen dramatically over the past decade.

Jean Dumas, head of the current demographic analysis section of Statistics Canada, was quoted as stating: "We are facing a very important change in the form of conjugal life ... The result will be a new form of living in which the responsibility for children and the elderly will be differently distributed."¹³

Although the NRTs do not currently affect a significant percentage of the population, they do represent a further significant change to the nature of the family. The legislation that regulates the legal family in our society cannot possibly cope with the new situations that arise with the new technologies; they were drafted with no consideration for the types of change we have subsequently witnessed. There are many pieces of legislation, created in a completely different social and factual context, that create difficult and potentially contentious issues when applied to the situations generated by AHR.¹⁴

When the courts are relied on to resolve matters of family law, they must, of necessity, look to existing legislation as the base point for decision making. In the absence of specific legislative direction, the courts can only apply pre-existing legislation and judicial principles to novel situations. This is a normal function of the courts; however, where new realities create issues of important social consequence, it is dubious whether it is appropriate to rely on judicial decision making on a case-by-case basis to resolve questions of social policy. Furthermore, the judiciary can only operate within existing parameters: it is not the role of the courts to make public policy decisions. As a result, the judiciary is constrained by policies, concepts, and categories invented to deal with the issues of another age.¹⁵

It is incumbent on legislators to provide binding direction to the courts on matters of public policy such as are presented by the assisted forms of human reproduction.¹⁶

[U]nless we start to make family law connect with how people really live, the law is either largely irrelevant or merely ideology: merely statements of the kinds of human arrangements the lawmakers do and do not endorse. The gap between law and practice is especially pronounced in the face of revolutionary scientific and technological changes.¹⁷

Genetic, Social, and Legal Significance of Parenthood

Introduction

Parenthood encompasses several different aspects of the relationship between an adult and child; it is not a simple category. As a social phenomenon it represents our notions about our biological inheritance, where and how we fit into our social environment, and our legal relationship with the people who raise us from infancy. In this section we examine the significance of each of those characteristics of parenthood.

Biological Significance

Historically, only two individuals could contribute to the biology of procreation: a male progenitor who contributed sperm and a female progenitor who contributed both ova and gestation. Biology in this sense was the determining factor, as there was an automatic link between procreation and parenthood: the biological mother was the legal mother unless she gave up her parental rights by consenting to adoption or by abandoning her child. The presumed father of the child was her husband (it was presumed that he is the only one who would have access to her reproductive capacities) and if he was not the biological father of the child, he could challenge his paternity by establishing that he was not the child's genetic progenitor. The ultimate determining factor of parenthood was therefore biology.

New reproductive technologies mean there no longer is an automatic link between procreation and parenthood, because the procreation of an individual can potentially involve the biological contribution of three individuals: the sperm donor, the ovum donor, and the gestator. In addition, apart from the biological contributors to the process of procreation, it has been argued that the third-party "intentional parents" who are involved have a right to be deemed "parents" of a child born of AHR. As a result of this, the attribution of parenthood has become a much more complicated issue.¹⁸

[W]here procreation can be comparatively impersonal for the adults involved, the link between biological procreation and the socio-legal parenting of a child both becomes and seems less necessitous. The

interpersonal involvement that frequently correlates with sexual intimacy also typically provides the social context in which adults plan to raise their children. If biological procreation can legitimately, that is non-sexually, occur apart from this personal context, then procreation can also more readily be seen as severable from the rearing of children: an individual could plan to rear a child biologically produced outside a particular intimate relationship. Conversely, because an individual could participate in reproduction without having either sexual intimacy or social ties with the other party(ies) to the procreation, an individual might more likely plan to procreate without intending to rear the child.¹⁹

Another relevant aspect of the biological significance of parenthood is the child's perception of his or her origins — how he or she came to be part of a particular family. Blood relationships are one of the factors that determine the answers our society gives to questions such as "Who am I?" and "Where do I come from?"²⁰ Furthermore, as another author noted: "The importance of reproduction to people is based partly on the continuity with nature and feelings of immortality that genetic transmission or reproduction involves."²¹ As a society, we have already experienced the upsurge in demand by adopted children to have access to information about their biological roots: action symbolic of how important knowledge of our genetic roots is. Whether that need is innate or learned is difficult to assess.

Social Significance

The concept of parenthood as a social and experiential relationship, not only as a genetic and biological phenomenon, is very important. In this context, "parenthood" is an issue of relationship, nurturance, shared experience, interdependency, and responsibility rather than biology.²²

This social significance of parenthood raises extremely important questions that should be addressed, as they are critical to the development of coherent legal policy in this area. Such things as the psychological reasons that motivate individuals to become parents²³ or to contribute to the parental aspirations of another by way of gamete donation require further study. The social dimensions of parenthood include, for example, the opportunity to develop an affectionate relationship with the child, to direct the religious and moral development of the child, and to provide a child with social connections (e.g., a personal history, a particular culture). Research on these issues is needed and would be most appropriate within the context of sociology, anthropology, or similar disciplines.

Legal Significance

The law is of significance to the issue of parenthood in two respects. First, it fashions rules, presumptions, and principles upon which the legal status of parenthood is conferred. In this sense it defines who the parent or parents of a child will be. Second, once a determination of parental status has been made, the law confers specific rights and imposes

particular obligations on those individuals who have the legal status of parent. Traditionally, we have granted parental status to "those persons with [a] biological and experiential connection" to a child.²⁴

As we demonstrate below, the laws of filiation have, in our more recent history, been constructed to grant legal parental status to both mothers and fathers primarily on the basis of biology and genetics derived from the presumption of filiation within the marital relationship. However, although these have been the main factors determining the attribution of parenthood, they are not the only legally recognized means of establishing a parental relationship. There is a strong tradition recognizing the importance of the social and psychological aspects of parenthood and attempting to incorporate them into the law.²⁵ The most obvious reflection of this in the law is the presumption of paternity, which is a social determination based on a man's relationship with the mother of the child. In addition, the law does recognize and facilitate adoption as a means of establishing legal parenthood, but only upon the termination of the parental rights of the child's biological parents.²⁶

Once the legal status of parent has been established, particular legal rights and obligations flow from the parent-child relationship. In general, parents have a right to custody, care, and control of their child; a right to name their child; a right to raise their child as they wish; and a right to educate their child and make decisions about the child's moral and religious upbringing. In turn, parents have an obligation to support their child in accordance with their means and to provide the necessities of life. Children also have rights of inheritance from their parents.

The various forms of assisted procreation challenge the legal significance of parenthood in two ways. First, by making it possible for more than two individuals to be involved in the procreative process, assisted procreation challenges the presupposition that a child can have a maximum of two legal parents — one mother and one father.²⁷ In addition, if we choose to retain the principle that a child should have only two legal parents of opposite sexes, we are forced to adopt a means by which such a determination of legal status is to be made.

The second challenge raised by assisted procreation concerns the divisibility of the rights and obligations of parenthood. Traditionally, these rights and obligations have not been granted to people who are not legal parents except in extraordinary circumstances. Although such rights and obligations have been shared between parents who are cohabiting and are often divided upon parental separation, the exercise and enforcement of parental rights and obligations are normally contingent upon legal parental status. However, in the context of assisted procreation, the issue arises as to whether those individuals who have participated in the procreative process but who may not have received parental status are entitled to any of the parental rights or incur any of the parental obligations.

It should be stated at the outset that how we choose to attribute the legal status of parent is ultimately a social policy issue. The decision as to

whether the law should reflect one single family form, thus holding it out as the only truly acceptable family structure, or whether the law should reflect more closely social reality is a decision that must be taken consciously and with adequate reflection on the interests at stake. In the following sections, we discuss the current legal regime that regulates the attribution of parental status: how one becomes a legal parent and what the effect of that attribution is in terms of rights and responsibilities. The current legal regime reflects a social reality that has been substantially changed by the advent of AHR, and as such it is clearly inadequate when applied to them. The resolution of the problem of who is legally defined as parent — and there must be a resolution — will turn not on issues of law but on issues of social and cultural acceptability.²⁸

Current Legal Regime

Introduction

One of the fundamental constructs of family law is the law of filiation, which regulates legal parent-child relations. While parenthood is usually a social issue, the rights and responsibilities of parent and child are set out in law. The law of filiation determines how all children fit into our existing legally constructed family. With minor exceptions, existing family law does not accommodate the complications in the attribution of parenthood that may arise when a child is born of assisted reproduction.

Before discussing issues of direct relevance to the method of integrating the children born of AHR into the legal construction of the family, it is important to understand how the law deals with the relevant aspects of the attribution of parental status.

In the following section we examine the legal notion of legitimacy and its consequences. In the next section we trace the law of filiation, looking at “filiation by blood” and at issues relating to adoption. Having examined how an individual attains legal parental status, we then examine the law of custody, access, and support.

Legitimacy

Whether or not a child is “legitimate” is a sociolegal construction with which most people are familiar. What it means is that the child was born to a married couple.

In most Canadian provincial jurisdictions, the distinction between legitimacy and illegitimacy has been abolished.²⁹ The consequence of this is that once parenthood has been established between the child and his or her mother and father, all of the rights and obligations of relationship automatically apply equally to all children, regardless of the marital status of the child’s parents. In those jurisdictions where there is no distinction, children born to unmarried parents are therefore at no disadvantage in law.

Filiation by Blood

In this section, the technical requirements for establishing filiation are set out, with each procedure under a separate subheading. While the relevant law in Quebec is included in each of these subsections, it is critical to note that the weight given to each is different in Quebec. To facilitate an understanding of how the law in Quebec functions, we will include here a brief synopsis of how each of the procedures fits together.

In Quebec, legal filiation is established by means of (1) title; (2) possession of status; (3) presumption of paternity; and (4) acknowledgment of paternity.

Title is the child's "act of birth,"³⁰ which is the certificate that sets out the day and place of the birth, and baptism, if performed, the child's sex, surname, and given names, and the names, surnames, occupation, and domicile of the mother and father.³¹

Possession of status relates to those who hold themselves out as the parents of the child. The current customary elements of possession of status are usually described as: (1) name: the fact that the child bears the name of the would-be parent; (2) treatment: the fact that the child is treated by the would-be parent as his or her own; and (3) reputation: the fact that the child is regarded by family and friends as the child of the would-be parent.

The Civil Code stipulates expressly that, where the act of birth is consistent with possession of status, there can be no contest to a child's filiation. The combination of those two things is irrebuttable.³²

The presumption of paternity is essentially the same in Quebec as elsewhere, although its weight is subject to the primordial nature of the act of birth and possession of status.

Acknowledgment of paternity is essentially the same as elsewhere.

(i) Registration of Birth

The vital statistics legislation (or equivalent) generally requires the parents of the child to be registered as such on the birth registration.³³

In some Canadian jurisdictions, in conjunction with the presumption of paternity, only the husband of the child's mother may be registered on the certificate as the father. The name of the father in such circumstances may not be left blank, unless the mother signs a sworn affidavit that she was living separate and apart from her husband at the time the child was conceived. Where the woman is not married (or where she has sworn that her husband is not the father for the above reasons), the name of the father is left blank unless both she and the father jointly request that he be so registered.³⁴

In British Columbia, Ontario, and Quebec, the model for registration is different in that the mother and father are both required to sign the birth registration (or, in Quebec, to sign a declaration of parenthood if not present at the registration).³⁵ Where the child's mother does not know who the child's father is or where she has not acknowledged him, the register

is often left blank.³⁶ It is then incumbent on the child's father to establish his paternity if it is in his interest to do so.

In December 1991, major revisions to the Civil Code of Quebec were given parliamentary assent. Although the provisions of the revised Civil Code of Quebec are not yet in force, it is anticipated that they will enter into force in 1993.³⁷

The provisions of the new Civil Code will require that the accoucheur (birth attendant) draw up an attestation of birth, identifying the time, place, and date of the birth, the sex of the child, and the identification and domicile of the mother.³⁸ One copy of the attestation will remain with the child's parent(s) and another will be sent directly to the registrar of civil status, with a copy of the declaration of birth.³⁹ The declaration of birth is made by the father and/or mother to the registrar of civil status within 30 days of the birth.⁴⁰ Only where the mother and father are married does one parent have the right to declare the filiation with regard to the other.⁴¹ In every other case authorization of the absent parent is required.

(ii) Presumption of Maternity

Until the advent of *in vitro* fertilization (IVF) using donated ova or donated embryos, the issue of motherhood was significantly less complicated: the woman who gave birth to the baby was always the baby's legal mother.⁴² Although the existing legislation in Canada does not stipulate a presumption of maternity, the civil law of Quebec and the common law of the other Canadian jurisdictions historically recognize the principle of *mater est quam gestatio demonstrat*:⁴³ the presumption that the woman who gives birth to the child is the child's legal mother.

This historically recognized principle is substantiated by the vital statistics legislation, which commonly defines "birth" as the complete expulsion or extraction of the fetus (or product of conception) from its (the) "mother."⁴⁴

As with other legislation drafted before the advent of the use of donated gametes or embryos, it is unlikely that the legislators considered the implications of these definitions when drafting the vital statistics legislation. It may or may not be appropriate within the current context.

(iii) Declaration of Maternity

In some jurisdictions there is provision for "any interested party" to seek a declaration that a person is or is not the mother of a child, potentially challenging the unwritten presumption that the woman who gives birth to a child is the child's legal mother.⁴⁵ The standard of proof is on the balance of probabilities. This means that the party bringing the application for a declaration must prove that it is more likely than not that the child's mother is other than the one legally so titled.

The Civil Code of Quebec permits a father or a mother to claim paternity or maternity, respectively, "of a child whose filiation in their regard is not established by an act and by possession of status consistent therewith." This means that a person who wishes to establish his or her

rightful parenthood of a child may do so. However, that right is significantly curtailed if the child's birth certificate is consistent with his or her "possession of status," meaning with whom he or she lives; that is, if the parents listed on the certificate are exercising everyday care and control of the child, there is an irrebuttable presumption that those people are the child's legal parents.⁴⁶

With the advent of the new technologies of reproduction and the possibility of separating the genetic mother from the gestational mother, motherhood is not so easily presumed. In none of the legislation in Canada is that issue directly addressed. The complications that arise as a result of the new forms of AHR are addressed later in this text.

(iv) Presumption of Paternity

As in the case of the presumption of maternity, a presumption of paternity functions as the starting point of the law; the most likely person to have fathered the child is deemed in law to be that child's presumed father.⁴⁷

Although the social and legal context of the family has changed in many ways, with the exception of Nova Scotia each Canadian jurisdiction has a provision covering the presumption of paternity in the legislation. In its present form, the presumption of paternity constitutes a rebuttable presumption (on the balance of probabilities) and relates to those children born into stable heterosexual relationships.

The legislation in most of the provinces stipulates that a man is presumed to be the father of a child born in the following circumstances:

- (a) the man was married to the mother of the child at the time of the birth of the child;
- (b) the man was married to the mother of the child and the marriage was terminated within 300 days of the birth;
- (c) the man married the mother of the child after the birth and acknowledged that he was the father of the child;
- (d) the man was cohabiting with the mother in a relationship of some permanence at the time of the birth of the child, or the child was born within 300 days after the person and the other ceased to cohabit;
- (e) the man has acknowledged paternity of the child and is so registered under the Vital Statistics Act or similar legislation; or
- (f) the man has been found by a court of competent jurisdiction in Canada to be the father of the child.⁴⁸

The legislation in Quebec is framed differently, although it maintains the principles of the presumption of paternity within marriage⁴⁹ and the 300-day rule.⁵⁰ In article 576, the Civil Code of Quebec stipulates that if the child is born within 300 days after the dissolution of the marriage but

after the mother has remarried, "her husband at the time of the birth is presumed to be the father of the child." The issue of voluntary acknowledgment of paternity is raised as an issue outside the presumption.⁵¹

Where the application of rules on presumption of paternity leads to the conclusion that there is more than one father (e.g., where a married couple separates and the woman lives with her new partner and a child is born to that newly formed couple within 300 days of the separation), the legislation in some jurisdictions stipulates that no presumption of paternity will be made.⁵² In Manitoba in this circumstance, the court will make a determination on the balance of probabilities which of the presumed fathers is to be deemed the legal father of the child.⁵³ In Alberta, if the court is unable to determine which one of two or more competing individuals is a parent, the court may make an order "declaring each of the respondents who, in the opinion of the court, might be a parent to be a parent for the purposes of this Act."⁵⁴

It is interesting to note that, while the legislation in Nova Scotia does not contain a presumption of paternity of the kind discussed above, its legislation regarding support obligations includes a definition of "possible father."⁵⁵

(v) Voluntary Recognition

In the absence of a presumption of paternity, the law facilitates voluntary recognition of paternity. This is generally done in the form of a formal written acknowledgment of paternity, which is filed with the registrar of vital statistics or with another designated official.⁵⁶

The Civil Code of Quebec stipulates that a voluntary acknowledgment of filiation is binding only against the person making the acknowledgment; it is not conclusive proof of filiation.⁵⁷ The same result is obtained by the legislation in New Brunswick and in the Northwest Territories.⁵⁸

(vi) Declaration of Paternity

In most jurisdictions any interested person may seek a judicial declaration of paternity. This provision typically applies to a declaration of maternity, too.⁵⁹ In Quebec, only the child and the would-be father can claim paternity before the court.⁶⁰

In Manitoba and Newfoundland, a declaratory order of paternity may be brought before the birth of the child.⁶¹ In Saskatchewan, where a child is born to a single woman, filiation proceedings may be brought before or after the child's birth.⁶²

(vii) Contestation and Disavowal

A man presumed to be the father of a child may bring an action to disavow paternity. Where the matter goes before the court, the birth registration (which may simply reflect the presumption of paternity) may be used, in most jurisdictions, as *prima facie* proof of the facts recorded in it.⁶³ In Quebec, an action to disavow or contest paternity may be brought before the court by the child's mother,⁶⁴ and in other jurisdictions such an action may be brought by "any interested person."⁶⁵

(viii) Proof of Paternity

The onus is on the man contesting paternity to provide proof that he is or is not the child's father. As was noted earlier, the presumption of paternity in some jurisdictions (particularly those that retain the legitimacy/illegitimacy distinction) is difficult to overturn. Alberta is one such jurisdiction. Having retained the distinction of legitimacy, the Vital Statistics Act in Alberta stipulates that despite the fact that the birth registration may be used as *prima facie* evidence of the facts within it, it may not be used to rebut a presumption of legitimacy (meaning a married woman having a child with another man cannot undo the effect of the presumption of legitimacy merely by arranging to have the birth certificate reflect the child's "real" biological father).⁶⁶ This does not preclude reliance on other types of evidence to prove the "true" paternity of the child.

The most convincing evidence of paternity in most jurisdictions is biological proof. This can be established by way of a blood test or genotyping (genetic fingerprinting). In the case of a man bringing an action in disavowal, a blood test will establish his lack of a genetic tie to the child.⁶⁷ This proof will overturn the presumption of paternity. Where an interested party brings an action to prove parenthood, that person may request that the alleged parent undergo a blood or other test to be submitted in evidence as to parenthood. The alleged parent must consent before such a test is administered; however, the court may draw an adverse inference from a failure to submit to the test.⁶⁸

(ix) Specific Legislation Regarding Artificial Insemination

(a) Newfoundland

The Children's Law Act in Newfoundland makes express provision for the filiation of children born of AI.⁶⁹ The legislation stipulates that where a man, married or unmarried, consents in advance to the insemination of his spouse, he is considered in law to be the father of the child. Section 12(5) further stipulates:

Notwithstanding a married or cohabiting man's failure to consent to the insemination or consent to assume the responsibilities of parenthood ... he shall be considered in law to be the father of the resulting child if he has demonstrated a settled intention to treat the child as his child unless it is proved that he did not know that the child resulted from artificial insemination.

To protect the donor of semen, section 12(6) stipulates that he is not, in law, the father of the child.

(b) Quebec

The Civil Code of Quebec at present includes two articles specifically aimed at regulating paternal filiation in the case of AI. The first is under the heading "Actions relating to filiation (1) Disavowal and contestation of paternity." Article 586 stipulates: "When a child has been conceived through artificial insemination, either by the father or, with the consent of

the spouses, by a third person, no action for disavowal or contestation of paternity is admissible." "Spouses" in this context means those who are legally married, as the Civil Code does not recognize unmarried unions. This article therefore applies only to the situation in which the husband has given consent to the artificial insemination of his wife, and it does not apply to consent given by a common-law spouse.⁷⁰ This means that where he has consented to the procedure, the legal husband of a woman giving birth to a child born of AID may not challenge the presumption of his paternity for the child, nor may anyone, including the child's mother, contest it.

The second stipulation regarding AI is under the heading "(2) Claim and contestation of status." Article 588 reads:

Any interested person including the father or the mother may, at any time and by any means, contest the filiation of a person whose possession of status is not consistent with his act of birth.

However, no person may contest the filiation of a person because that person was conceived through artificial insemination.

The second paragraph of article 588 aims at prohibiting all contestation of filiation when there has been recourse to AI. The intention of this is clearly to protect the child born of AI.

Although article 586 is clearly a method of preventing a married man from contesting his paternity for a child who was conceived with his consent by AI, it does provide him with a way of challenging that status if he did not consent. Had he not given his consent before the AID, even where he is registered as the father on the child's birth certificate, he may challenge his paternity on the ground that he did not consent.⁷¹

As was noted above, the Civil Code of Quebec is undergoing fundamental revision. Proposals for change affecting, among other things, issues surrounding AHR and family law are included in Bill 125, which is expected to take effect in 1993.

Although most provisions under the heading "Filiation by Blood" remain the same in Bill 125 as under the present Civil Code, there is no equivalent to articles 586 or paragraph 2 of 588 of the existing Civil Code of Quebec (i.e., the provisions relating to AI).

Bill 125 introduces a new section, which deals with Medically Assisted Procreation (Title two, Chapter 1, Section III). Within this section the following principles are enunciated:

1. The use of third-party genetic material by way of medically assisted reproduction creates no filial bond between the third party and the child born of that procreation (art. 538);
2. No person can contest the filiation of a child for a reason stemming from the medically assisted character of his procreation, and the child is not permitted to claim another status (art. 539);

3. The husband of the mother can disavow the child or challenge its recognition if he had not consented to the medically assisted procreation or if he proves that the child is not born of such assistance (art. 539, para. 2);
4. A person who consents to medically assisted reproduction and refuses to recognize the child resulting therefrom incurs responsibility toward the child and the mother of that child (art. 540);
5. Agreements for procreation or gestation for the benefit of another are null and absolutely unenforceable (art. 541);
6. Nominative information relative to medically assisted reproduction of a child is confidential.

The court may release nominative information to the medical authorities in question where it has been established that there is a risk of serious harm to the child's health if such information is withheld (art. 542).

(c) The Yukon

The Yukon has adopted legislation that is precisely the same as that in Newfoundland and described previously.⁷²

Adoption

The legal alternative to the establishment of filiation as above, which one could say is generally biologically based, is the establishment of legal parenthood by adoption. Where adoption is the basis for the legal relationship between a child and his or her parent, there is generally no genetic link between the two, and the filial bond is grounded in the intention of the parent to assume the rights and responsibilities for a child born to another couple or, in the case of a step-parent adoption, to the adopting parent's spouse and his or her previous partner.

(i) Termination of Parental Rights

With the exception of step-parent adoptions, before a child can be the subject of a legal adoption, the legal relationship between the child and both of his or her legal parents must be terminated. In Canadian law, it is not possible for a child to have more than one legal father and one legal mother. This means that where a child is presumed or declared to have a legal parent, that parent either must consent to the adoption or must have abandoned the child or have been deemed by the courts as unfit to parent the child.⁷³

All parental rights and obligations must be terminated before the adoption process may be completed. The reason for this is that adoption simulates the biological bond between a parent and a child and the adopting parent essentially steps into the shoes of the previous legal parent — together they do not fit.

(ii) Who Can Adopt

A child whose legal parents' rights have been terminated may be adopted in all jurisdictions in Canada by a single adult⁷⁴ or by a legally married couple.⁷⁵

In Manitoba, Ontario, and Quebec, a child may be adopted by a couple living in a common-law relationship.⁷⁶

Although most of the provincial legislation recognizes de facto relationships, it is interesting that, with the exception of Manitoba, Ontario, and Quebec, an adoption will be approved in nearly all the provincial jurisdictions only for a couple that is legally married.⁷⁷

(iii) Effects of Adoption

Once an adoption has been completed, the adopted child becomes the child of the adopting parent as if that child had been born to that parent.⁷⁸

(iv) Placement

In most Canadian jurisdictions a child may be adopted through a state-run agency or through a licensed agency.⁷⁹

In Ontario, placement of a child can be only through an agency or a licensee unless the child is being placed with a relative.⁸⁰ This means that the province must approve any agency conducting the process of adoptions; private placement agencies may be licensed.

The direct placement of a child by the child's parents or guardians with the prospective adoptive parent(s) is also permitted in a number of jurisdictions.⁸¹ There are no restrictions on who may assist in the process in Nova Scotia, Prince Edward Island, the Northwest Territories, or the Yukon. Notice of direct placement of a child must be given to a specified functionary in each of these jurisdictions.⁸²

Private placement adoptions (outside placement with relatives) are not permitted in either Quebec or Newfoundland.⁸³

The specifics of the rules and regulations for the placement of children for adoption vary greatly from jurisdiction to jurisdiction in Canada and are not dealt with further here.

(v) Issues of Consent

Before a child may be adopted, consent to the termination of parental rights must be given by his or her legal parents or guardians, or the child must have been declared abandoned by law.⁸⁴

In other provinces, every parent whose name appears on the birth record of the child and any person who has been declared to be a parent of that child by a court must give consent to the adoption.⁸⁵ In Saskatchewan, the consent must be given by the child's "birth parents."⁸⁶

In Prince Edward Island, the consent must be given by both parents except that "where the mother is unmarried at the time of her signing the written consent to adoption and the child has not previously been adopted, only her consent is required."⁸⁷

In Manitoba, when a man brings an application for a declaration of paternity to the court, no order for adoption may be granted until all appeals from that process have been completed.⁸⁸

The Civil Code of Quebec defines consent to adoption in the following way:

Consent to adoption may be general or special; if special, it may be given only in respect of an ascendant of the child, a relative in the collateral line to the third degree or the spouse of that ascendant or relative.⁸⁹

The effect of this is that those with the authority to consent to adoption may give a "general consent," which leaves the decision as to who takes placement of the child to the agency. They may, alternatively, give "special consent" — permitting a designated individual to adopt the child. This designated individual must fit the list in article 607 noted above. This article then effectively precludes private placement adoptions unless the child is placed with one of the child's relatives.

(a) Consent to Adoption of a Newborn Infant

With the exception of Alberta, Quebec, and the Yukon, each of the jurisdictions stipulates that consent may not be given for the adoption of the child until the child is between 3 and 15 days old.⁹⁰

In most of the provinces there is provision for the revocation of consent to adoption. The revocation period either is calculated as a period of days after the date the consent is given⁹¹ or is contingent on the child not having been placed for adoption,⁹² or simply where an adoption order has not been made.⁹³

(vi) Step-Parent Adoption

In each of the provinces with the exception of Newfoundland, there is legislation that specifically assists individuals who wish to adopt the child of their spouse (i.e., their step-child).⁹⁴

In Alberta, a step-parent seeking to adopt the child of his or her spouse may still be subject to a home assessment report to determine his or her suitability to parent the child.⁹⁵ The legislation in British Columbia stipulates that a step-parent adoption may take place only when, at the time of hearing the application, the child has resided with the applicant for at least six months and the court is satisfied that the conduct of the applicant and the conditions under which the child has lived are appropriate.⁹⁶ In Manitoba and Ontario, such screening may also be ordered.⁹⁷

It is worth noting that the use of the term "spouse" (*conjoint*) in the Civil Code of Quebec does not include "common-law spouse," and therefore a step-parent adoption by a common-law spouse is not recognized by the Code.

(vii) Right of Access to Information

There are two different issues involved regarding an adopted child obtaining information about his or her biological parents. The first is whether such a child should have a right to biological- or health-related information about his or her parents; the second is whether the child should have access to nominative or identifying information. The same is true regarding whether a couple or an individual who has adopted a child has access to information on that child.

(a) Nominative/Identifying Information

Access to information regarding adoption is regulated in each of the jurisdictions in Canada. In general, information regarding the individuals who surrender a child for adoption, the child him- or herself, and those who adopt a child is confidential. However, each province has a system permitting the birth parents and adopted child by mutual consent to become reacquainted once he or she is of age.

In Nova Scotia, the Northwest Territories, and Prince Edward Island, the law stipulates that the sealed record containing the information relied on by the court before making an order for adoption can be opened only by the Minister to obtain only that information "he deems necessary,"⁹⁸ or only on order of the court.⁹⁹ The legislation in each of the other Canadian jurisdictions includes specific reference to post-adoption access to information by an adult adoptee and his or her birth parents or blood relatives.¹⁰⁰

There are two methods of facilitating access to information between natural parents and an adopted child. The first, called a "passive registry," entails simply maintaining a registry for those who wish to obtain the identity of their adopted child or blood relative. Until such time as both sides are registered, no such information can be given out. The other, called an "active registry," entails the agency maintaining the records actively, although discreetly, pursuing the unregistered party to seek his or her consent to the revelation of his or her identity to the other party.¹⁰¹

Identifying information will also be revealed in some jurisdictions for health reasons.¹⁰²

Although the law in Quebec permits an adopted person of "full age" to obtain identifying information on his or her parent(s), this applies only "if they have previously consented thereto."¹⁰³ The law stipulates clearly that there should be no solicitation for consent from the other side, but the courts have held that simply informing a birth parent (or the adopted child) of the other's interest in making contact is not a breach of confidentiality, nor is it solicitation.¹⁰⁴

In British Columbia, a birth relative or adult adoptee may file a veto stipulating that he or she wishes to be contacted only if there is a compelling medical need for contact.¹⁰⁵

(b) Non-Nominative Information

The information in this category is of two distinct types. One is social information about the family of the relevant party. The other is health-related information, which will increasingly include genetic information. Certain jurisdictions permit the minister to release non-identifying information of a general nature to the child who is the subject of an adoption order, his or her biological parents, biological grandparents, siblings, and so on.¹⁰⁶

The law in Quebec was amended in 1982 to include a provision that stipulates that, upon request, at the time of adoption the adoptive parents

have a right to request a summary of the child's antecedents, and the child's natural parents may request a summary of the adopter's antecedents.¹⁰⁷ These summaries are not to breach the anonymity of the respective parties.¹⁰⁸

Commentary on Filiation

Introduction

In the preceding section, the existing legislation that regulates the legal ties between a parent and his or her child is set out in some detail. It is critical to understand how this legislation works before one can come to terms with the problems posed by the NRTs, particularly with regard to donated gametes or embryos. The basic purpose of the legislation is to facilitate the determination of a particular child's parents. There are currently two general methods of establishing filiation: one is biology, which is somewhat tempered by the presumptions in the law reflecting social norms more than biology itself; the second is adoption. Currently, to establish that a man is the legal father of a child or a woman is the legal mother of a child, one must rely on this set of rules.

Legitimacy

The legitimacy or the illegitimacy of children is a legal construction that reflects a social attitude to reproduction.¹⁰⁹ Black's Law Dictionary defines legitimacy as: "Lawful birth; the condition of being born in wedlock; the opposite of illegitimacy or bastardy."¹¹⁰ The distinction between legitimacy and illegitimacy stems from outdated social realities in that today 24.4 percent of Canadian children are born out of wedlock. Historically it played a much more significant role than it does today, and the distinction has been abolished in most Canadian jurisdictions. Given the reality of our society and the growing acceptance and number of children born out of wedlock, many feel there is no longer a need for the distinction to exist in law.¹¹¹

Historically, whether a child was legitimate or illegitimate had significant consequences. At common law, the father of an illegitimate child had no parental rights or duties.¹¹² In addition, "[i]n the ancient world the problem of illegitimacy was often dealt with by the simple expedient of destroying the future bastard's mother before the child could be born."¹¹³ An illegitimate child was deemed not to be the kin of his or her father for the purposes of inheritance,¹¹⁴ support, and custody. The implications of this in times when a woman had no rights were significant.¹¹⁵ A woman was deemed to be the chattel of either her father or her husband; if her father was dead and she was not married, one of his kinsmen was given guardianship over her. The child had no one to rely on for support, for

unless she was from a wealthy family, it was not possible for a woman to support a child on her own. At common law — before modification by statute — a child born to a single woman was *filius nullius* and therefore was the child of no one.¹¹⁶

Jenny Teichman defines an illegitimate child as “one whose conception and birth did not take place according to the rules which, in its parents’ community, govern reproduction.”¹¹⁷

The legitimacy/illegitimacy distinction seems easy to comprehend at first but — as is clear from the above definition — it carries with it many sociological and anthropological connotations: it is not a purely legal term.

The common law has been substantially modified by specific statutory provisions regulating the responsibility of a father for his children, whether or not they are born within wedlock. This, combined with the fact that 10 of the 12 Canadian jurisdictions have abolished the distinction between legitimacy and illegitimacy, reveals that the distinction is not useful or appropriate.

Filiation

To facilitate an understanding of the next section of this paper, it is helpful to review the general process of establishing legal parenthood under the present law; as was noted above, the law in Quebec functions somewhat differently.

Filiation by “Blood”

- The woman who gives birth is presumed to be the legal mother of the child.
- It may be possible to challenge this presumption by seeking a declaration of maternity.
- The woman’s spouse (if married, or her partner in a stable heterosexual relationship) will be presumed to be the father of a child born to her.
- The presumption means that no proof is necessary to establish the paternal relationship between the spouse and the child.
- A man who is presumed to be the father of a child has a right to bring an action in disavowal to absolve himself of the legal responsibility for a child who is not his genetic offspring.
- As soon as a child is born, a certificate of birth must be signed setting out the child’s parents; the procedure for signing that certificate differs slightly between provinces, and the implications of the certificate differ somewhat in Quebec.
- In three jurisdictions, where a man has consented to the use of AID by his spouse, he will be presumed to be the father of the resulting child (this presumption cannot be challenged).

- Where there is no presumed father for a child, a man may seek a declaration of paternity, whereby the court will give him the designation if he can establish on a balance of probabilities that he is the biological father of the child.
- The father may acknowledge paternity and register that acknowledgment. (This may be complicated by the need for the child's mother's signature.)

Filiation by Adoption

- Adoption has the effect of placing adoptive parents in the exact position of parents by "blood."
- Before an adoption may be finalized, all ties between the child and his or her existing legal parents must be broken. (In the case of step-parent adoption, the ties between one parent and the child must be severed.)
- This means that the child's presumed mother must have consented to the adoption, or must have had her parental rights terminated by the courts.
- Where the child had an identified legal father, that father must also have had his parental rights terminated either by consent or by court order.
- If the child's biological father has not been given legal recognition, until such time as he seeks the legal attribute "father" he does not have any of the contingent parental rights and therefore there are no rights to be terminated prior to the adoption order being granted.
- In some jurisdictions, the adoption order may not be granted if a man alleging paternity for a child up for adoption seeks a judicial declaration of his paternity, until such time as a final decision on the issue is made.
- Before a placement may be made by a public agency, an assessment of the type of home the child will be placed in must be made.
- Only in a limited number of jurisdictions is such an assessment done automatically where there is to be a step-parent adoption.
- Both nominative and non-identifying information is maintained on the birth parents of adopted children.
- Each province has a system of permitting the birth parents and the adopted child by mutual consent to become reacquainted once the child comes of age; the system for access to relevant information is controlled.

Many of the provisions in the existing legislation, when adapted slightly, may be relied on to accommodate the reality of birth by the new

technologies. It has been argued that because this is so, the law could be left untouched. Although this may be true in general, there will unquestionably be issues that the courts will have difficulty deciding without adequate direction, for example in the form of new legislation.

In the following section, we will examine the complications that arise as a result of applying legislation such as that set out above to deal with the new biological realities of procreation.

(i) The Establishment of Paternity

(a) Presumption of Paternity

The presumption of paternity is the law that deems a particular man is the legal father of a child. The function of a presumption is to provide a starting point in the law. It means that it is not incumbent on the father of the child to prove his paternity unless the child is born outside one of the existing presumptions.

To a large extent the law of paternity has always been based on "inference rather than certainty."¹¹⁸ Legal presumptions of paternity reflect a need to compensate for the lack of certainty in the biological reality of paternity. The most likely candidate to be the father of a child is the man who should be the only one having sexual intercourse with the mother. Historically, this presumption related only to the legal husband of a woman giving birth to a child. The reason for the presumption of paternity is arguably based on the fact that, historically, while motherhood of a child could be proven by the act of giving birth, fatherhood was much more difficult to prove. To ensure that the woman's husband's rights were clearly defined, the presumption was that as the man had exclusive right to the woman's reproductive functions, he could be presumed to be the father of the child. This presumption is based on a social reality rather than a biological reality (society could turn a "blind eye" to the possibility of adulterous relationships leading to procreation).¹¹⁹

Historically, this presumption of paternity within a marital relation was one of the most difficult presumptions to overturn. It disallowed strangers to the marriage — even the actual biological father himself — to challenge that presumption.¹²⁰ One could presume that the reason for this was that society had a vested interest in ensuring that a child was born into a family and would have the benefit of a legal mother and a legal father. It also protected the "property rights" aspects of paternity.

The advent of assisted reproduction has created a new twist in the presumption of paternity. It used to be that the marital relationship, or the existence of a stable heterosexual relationship, was the basis upon which the presumption was created. The presumed father in that case had the right to disavow paternity by establishing, as a biological fact, that he was not the child's father. Although the presumption of paternity based on the relationship between a man and a woman acts as the starting point for establishing the paternal relation, the ultimate determining factor is biology.

In a situation where donated gametes (by way of AID) are relied on by a couple who wish to have a family, the intention of the "presumed father" becomes a relevant issue. In this circumstance, is it appropriate that he should have a right to absolve himself of the legal obligations of paternity by proving an absence of a genetic link between himself and the resulting child? Where the legislation retains a rebuttable presumption of paternity, one that can be rebutted with proof that the presumed father has no genetic link to the child, a man in the above situation, despite his intention, may technically absolve himself of parental responsibility. This means that if the paternity of a child born of AID is put to a biological test, the child will have no father, as, in practice, donors remain anonymous. Therefore, the child will have no identifiable biological connection to a male. Apart from the technical defence against paternity available to a man who is not a child's genetic father, depending on the circumstances the courts may or may not permit him full absolution. The courts have held that a man who consented to the donor insemination of his spouse could not successfully challenge his paternity.¹²¹ The problem in this sort of case is that, in the absence of legislation regarding "consent" such as that in Quebec, Newfoundland, and the Yukon, parties to such an action will have no way of knowing what the result of this litigation might be. In the interests of preserving the child's "right" to two parents (or perhaps the best interests of the child being better protected by having two parents), the courts have often ruled in favour of attributing paternity wherever that is possible: "courts have gone to great lengths to provide every child with precisely one mother and one father."¹²²

Where there is a rebuttable presumption of paternity one must look to who has a right to rebut it. In each of the Canadian jurisdictions, a challenge to filiation may be taken by any interested party. If a man, such as the sperm donor, could produce *prima facie* evidence of his biological link to the child, the court would likely entertain his action in paternity as against the presumed father of the child in question. (Where there is legislation relating to AI, this would not be the case.) The courts would, once again, have to balance the rights of the respective parties and the child's best interests to make a determination of paternity.

As with any other issue, where the courts are relied on to extend definitions to accommodate new situations, there can be no certainty in the application of the law.

(b) Consent Legislation

One of the most common legislative solutions to the problem of the respective responsibilities of sperm donor and intended social father is the adoption of legislation similar to that in force in Quebec, Newfoundland, and the Yukon. In that legislation, where a man consents to the AI of his spouse with donor sperm (whether or not the couple must be married is a separate issue), the presumption of paternity becomes irrebuttable. Setting this out in law prevents a man from absolving himself of parental responsibility for a child he intended to father.

However, it is unclear what the word "consent" in this type of legislation was intended to mean. Was it intended to mean that without consent the woman is not entitled to be artificially inseminated with donor sperm? Or was it intended to mean that without consent the presumed father retains the right to rebut his presumed paternity? We are in agreement with the Law Reform Commission of Canada on this point when they state,

consent here is merely a defence in bar against any action in disavowal of paternity in cases involving parentage, divorce or successions. Therefore, the effect of the provision is not to recognise the husband's authority to decide, but rather to attach consequences to his consent by preventing him from alleging the absence of a biological link to disown a child whose conception he desired.¹²³

The primary purpose, then, of the "consent legislation" is to create an irrebuttable presumption of paternal responsibility in a case where a man intended to father a child born of donor sperm. The requisite manifestation of that intention is his consent. The effect of his consent is a binding paternity that is effectively a compromise of the legal notion that paternity is ultimately a biological issue. *Intention* has thus been enshrined in the law as a relevant determinant in the attribution of parental status.

Where a male spouse did *not* consent to AID as a means of having children, the presumption of paternity would still take effect but the man would have a remedy in an action for disavowal of paternity. A blood test or deoxyribonucleic acid (DNA) fingerprinting would provide adequate evidence of his lack of biological relationship with the child.

(c) Written Consent

Should the paternity of a child born of AID be challenged, any evidence should be admissible to establish that the requisite consent had been given in the above situations where there is consent legislation. At this stage, it becomes a simple problem of the rules of evidence. To simplify the evidence issue, it would be appropriate to require that spousal consent to donor insemination be given in writing. Such written consent would be binding on the parties unless either one or the other could establish grounds for vitiating the consent (i.e., through fraud, coercion).

However, where legislation would require the consent of a spouse, it is important that it be clear that this does not mean that consent is necessarily required before a woman could have donor insemination, unless that were expressly stated in the legislation or regulations; the consent would refer solely to consent to the assumption of parental responsibility.

In the Canadian jurisdictions that have enacted consent legislation, there is no mention of the form the consent should take.

(d) Paternity Where a Gestational Mother Is Relied On

One possibly unintended effect of the consent legislation drafted in Canadian jurisdictions is to make consent to the procedure, rather than intention to parent, the determining factor in the attribution of parenthood.

In a case where a married woman decides to act as a gestational mother (i.e., where she is artificially inseminated with the sperm of the child's intended father to give birth to a child for him to raise), the issue of consent under that type of AID legislation has serious complications.¹²⁴ Where her husband consents to AI with the sperm of the intended father, he is irrebuttably presumed to be the father of the child. This would mean that before the child's intended parents could hope to have legal parenthood, both the gestational mother and her husband would have to give up the child for adoption. The existing adoption law in Quebec and Newfoundland would prevent the couple from designating the intended parents as the adoptive parents, as there is no facility for private placement adoptions in either province.

A practical solution to this problem has reportedly been found in some jurisdictions by the gestational mother's husband signing an affidavit of "non-consent." This affidavit states that he does not consent to the AID and therefore refuses to accept paternal responsibility for the resulting child. This is, of course, not the case; if he truly did not consent to the arrangement he would merely give his written consent to the AID and also make it clear that he would not consent to a subsequent adoption by the sperm donor, and he would successfully thwart the intentional parent's objective.¹²⁵

Where such an arrangement is undertaken in a Canadian jurisdiction not having the consent legislation, the matter is less complicated. Where a married woman is inseminated with sperm from the commissioning father, the existing presumption of paternity will apply. As it is a rebuttable presumption, the child's biological father will have a right to establish his paternity. He may do this by registering as the child's father on the birth certificate in those jurisdictions where that is possible, or by seeking a judicial declaration of paternity. Once he has been established as the child's legal father he may then assume custody of the child. The genetic/gestational mother would then consent to the child's adoption by the child's father's wife, under the step-parent adoption rules.

The establishment of paternity in this situation is then once again based on a genetic identification; once the biological link has been established between the child and the child's biological father, the latter would appear to have all of the rights and responsibilities contingent on legal paternity. The question of who takes precedence where there is a dispute over custody is dealt with in the section on "Custody and Guardianship."

(e) *Fatherless Child*

Paternity is not always clear; in some cases, the determination of biological paternity is impossible, either because the child's mother had sexual intercourse with a man whose name is unknown or with a number of men over the same period, or because she may simply decide to refuse to disclose the identity of the man who made her pregnant.

In a jurisdiction with a rebuttable presumption of paternity, where a married woman becomes pregnant by AID and her husband decides to disavow the resulting child, the effect is the same as the situation described above where the child's father is not identified: the child has no legal father. In the absence of clear legislation to the contrary, it would be within the right of the child or the child's mother to bring a paternity suit against the donor of the sperm, just as it would be within their right to bring an action to establish paternity after a birth resulting from sexual intercourse.

Two significant policy issues are raised by this possibility: the first is whether sperm donors should be held responsible as legal fathers to the children born of their sperm. The second is whether access to donated sperm should be made available to single women. The first of these issues is addressed here and the second is addressed later in this paper.

(f) Sperm Donors — Potential Fathers?

One of the most common recommendations made by law reform commissions and others studying legislative reform in this area would require a donor to renounce all of his parental rights in gametes.¹²⁶ However, donors would retain the right to revoke consent for the use of their sperm up until such time as they have been used in the process of fertilization.

In the jurisdictions that have adopted legislation on AID, there is generally a provision that absolves donors from parental rights and responsibilities. Quebec's Bill 125 stipulates that "participation in the parental project of another person by way of a contribution of genetic material to medically assisted procreation does not allow the creation of any bond of filiation between the contributor and the child born of that procreation." Without such legislation, a waiver of parental rights is binding only on the donor and is no guarantee against the child asserting his or her rights against the donor as the child's legal father;¹²⁷ however, the absence of identifying information would make any action against the donor impossible. There is no requirement that identifying information be maintained on any donor, and donations are often given anonymously.

In Canada, with the exception of the three provinces that have adopted legislation absolving donors from parental rights and responsibilities, it is not at all clear to what extent donors could be held liable for obligations for children born of their sperm.

The Uniform Parentage Act in the United States affirms "the right of all children to a legal relationship with, and support from, both parents, regardless of the parent's marital status or wishes."¹²⁸ Where this legislation has been adopted, the donor is absolved of any parental responsibility when his sperm is used to further the parental aims of a married couple; however, the donor is not statutorily absolved of this responsibility when his sperm is used to inseminate an unmarried woman. This means that the child's mother, the sperm donor, or the child can assert the paternity of the donor.¹²⁹

However, in California, the statutory provision absolves all sperm donors of the legal status of paternity irrespective of the recipient's marital status. It has been argued that, therefore, the child would be foreclosed from any legal action against the biological father.¹³⁰ The legislation in the state of Oregon is similar to that in California in that it severs the rights and obligations between the donor of sperm and the child resulting therefrom.¹³¹

(ii) The Establishment of Maternity

Unlike the establishment of paternity, maternity has always been, and for the most part still is, a fact that can be very easily established: the woman who gives birth is the uncontested mother of the child. The existing presumption of maternity in the law is unquestionably a reflection of this simple process of identification. At no time in the past has it been necessary to determine whether the basic element of the presumption is genetics or gestation. It is clear that the advent of the new techniques of AHR has an impact on the "natural" order of things.¹³²

This is the first time in history that we have had to deal with the possibility of a completely different biological reality: two women can be physically involved in the genetic and biological process of the creation of the same child. To this physical extension to the process of childbirth we can also add the potential implications of the "intentional mother," the woman who relies on the genetic and the gestational capabilities of other women to produce a child to fulfil her own parenting objectives.

Given the new reality, there are potentially three competitors for the attribution of legal maternity. The first is the genetic mother whose claim to maternity is based on her genetic tie with the resulting child. The second is the gestational mother, whose claim to maternity is based on her biological relationship with the child — the fact that she carried the child within her body for approximately 38 weeks and then gave birth to it. The third is the woman who commenced the whole process by commissioning the requisite genetic contribution and gestational contribution while intending from the outset to act as the child's parent. This latter situation is dissimilar to an adoption situation because in preconception arrangements the intention to parent a particular child is established before insemination; the intention of the commissioning parents is the very reason for the child's birth.

To face the multitude of potential problems that can arise from this new situation, it is important to assess carefully the implications of retaining the existing presumption of maternity. If we decide it should be changed, we must examine carefully what the implications would be.

In the following section we examine the effect of each of the different forms of assisted reproduction on the attribution of motherhood.

(a) Maternity and AID

Where AID is relied on by a woman who wishes to have and raise a child, there is no issue as to maternity; the only parental questions that arise relate to paternity and have been discussed previously.

(b) Genetic/Gestational Motherhood

In this situation, a "third-party" woman is relied upon to fulfil the procreative intention of a man and his partner. Using the sperm of the child's intentional father or donor sperm, the woman becomes pregnant. (The issues arising in the context of lesbian couples are somewhat more complex and are dealt with in the next subsection.) The woman who bears the child is genetically related to that child but at the outset did not intend to retain maternal rights and responsibilities for the child.

Here, the woman is unquestionably the child's biological and genetic mother, for she has contributed both the genetic material and the gestation. The issue is whether she can be bound by her pre-pregnancy intention to terminate irrevocably her maternal rights. The critical question is whether an individual's intention to parent or not to parent should be the determining factor in establishing who has precedence in the attribution of parenthood.¹³³

Where a genetic/gestational mother is relied on to fulfil the parental dreams of a "commissioning couple," there is a clear shift away from the traditional approach to bearing children. In the case where the commissioning father contributes sperm, there is often no social relationship between the child's father and mother; the relationship itself is based on the intention to procreate for the benefit of the child's father. (Where a woman acts as a genetic/gestational mother for a friend or for a family member, that situation falls outside the scope of this argument.) The woman enters into the relationship with the full knowledge that she is to become pregnant for the benefit of the sperm contributor. The woman is undertaking a function that will take at least 38 weeks of her life (plus the time it takes her to become pregnant); she will undergo marked physiological and psychological changes, and she will have a long period of time within which to reconsider and question her decision to enter the contractual arrangement.¹³⁴ Surrogate agreements require making personal choices and commitments months in advance of the performance of the contract. Therefore, there is much time for participants to change their minds. Also, changed circumstances such as divorce, death, illness, or marriage may cause a party to want to modify or terminate the agreement. Given the nature of the process, the question is whether a woman should be irrevocably bound by her pre-insemination consent to the termination of her parental rights.

Suppose that a surrogate announced, soon after it was confirmed that she was pregnant, that the deal was off. She might say, for example, that she no longer felt she was psychologically adjusted to the idea of surrogate motherhood, and she wanted an abortion. Or she might say

that she wished to bear the child but keep it herself. Could a court then step in and compel her to complete the contract — to bear the child and hand it over to the adopting couple? The compulsion involved would be of a uniquely odious form. The contract is not like an ordinary contract for services since its fulfilment involves a physical invasion of the contractor's body. The surrogate could not, like any other contractor, walk out of the work-place. She is the work-place. Should she be taken into custody to prevent her obtaining an abortion? Should her baby be taken from her against her will immediately after birth? Even in ordinary contracts for personal services the courts are unlikely to award specific performance allowing only damages. In such cases judges have held that the analogy with slavery is too close. How much more so in the case of surrogacy.¹³⁵

In the civil law of Quebec, it is impossible to renounce parental authority before the birth of the child, as such a renunciation would be contrary to public policy.¹³⁶ That principle is reflected in most of the common law jurisdictions in Canada by the provision in the adoption laws that stipulate that consent to adoption cannot be given until the child is at least four days old, and any consent given before that is not enforceable. The parallel between surrogacy arrangements and adoption is addressed in the next section of this paper.

With regard to maternal filiation, the problems that arise where a genetic/gestational mother is relied on are relatively limited at present: the woman bearing the child would be considered in law to be the child's mother. Her maternal rights and obligations would have to be terminated before anyone could supplant her. In general, one would anticipate that this would be done by consent when the woman gave the child up to the commissioning couple after the child's birth.¹³⁷

Once she had consented to the termination of her rights, it would be possible for the woman in the commissioning couple to proceed, by way of step-parent adoption, to adopt the legal child of her husband. This way the intentional parents, those who commissioned the birth with the genetic/gestational mother, would attain their objective, which is to be the sole legal parents of the child.

Should the genetic/gestational mother fail to consent to the termination of her parental rights, and should she refuse to give up custody of the child to the child's biological father, the matter would fall within the ambit of the law relating to custody and access. To attempt to enforce any rights, it would be incumbent on the child's biological father to bring an action for a declaration of paternity combined with a petition for custody. He could attempt to have the genetic/gestational mother's parental rights terminated by establishing unfitness, or he could merely attempt to obtain sole custody of the child.¹³⁸ The genetic/gestational mother's refusal to consent to the termination of her parental rights would result in the commissioning woman (the wife of the child's biological father) having no way of establishing a legal relationship between herself and the child; her right to

parent would be completely contingent on the right her husband established vis-à-vis the child. Should he obtain custody in a dispute situation, she could then establish a relationship with the child and act *in loco parentis*, which would give her, over time, certain rights and obligations for the child.¹³⁹

In Quebec, Newfoundland, and the Yukon, where the genetic/gestational mother is married there would be an irrebuttable presumption that her husband (had he given his consent to the AI) is the father of the child. To thwart the commissioning couple, the genetic/gestational mother and her husband would have to sign the birth register and then maintain custody of the child to provide the child with "possession of status." In Quebec, the combination of the certificate of birth with the possession of status becomes an irrebuttable presumption of parenthood. This, along with the provisions regarding the impossibility of challenging the filiation of a child born of AI in the courts, would make it an almost impossible hurdle for the commissioning couple. They would have to bring their action immediately upon the birth of the child in the hope that they would prevent the establishment of "status" and that they would be able to establish that no consent to the assumption of paternal responsibility was given.

Legislators considering law reform in this area must consider the grounds upon which maternity should be attributed. When the genetic/gestational basis of the existing presumptions of parenthood is tempered by the impact of intentional parenthood, one must consider the weight to be attributed to the intention of an individual to parent. Should the intentional parents (the commissioning couple) be presumed to be the parents of the child right from birth? Should that presumption be rebuttable so as to allow the gestational mother or any other interested party the right to challenge the presumption? Should it be an irrebuttable presumption, meaning that the intention to parent established prior to insemination is absolutely binding? Should the intentional parents be entitled to sign the birth registry as the child's legal parents right from birth, or should they be obliged to comply with the provisions similar to those for adoption?

There is some argument in favour of the intentional mother being the child's legal mother (i.e., being presumed to be the child's mother because of her intention to parent combined with her relationship with the child's biological father).¹⁴⁰ It has been suggested that the law should favour the commissioning woman by making her the child's presumed legal mother (much in the same way that the husband of a woman relying on AID is presumed to be the child's father). This would protect the objective of the intentional parents and would designate the intention to parent as the primordial element in the attribution of parenthood.¹⁴¹ Where such a presumption does not favour the commissioning woman, the only way she can gain parental rights to the child is by way of step-parent adoption. Failing that, should her husband die before the birth, unless the genetic/gestational mother was prepared to permit her to adopt (by way of private

adoption), there would be no way she could assert a right to the child.¹⁴² It would also mean that where the child does reside with his or her biological father and social mother but where such an adoption does not take place, should the couple separate the social mother could only seek custody or access to the child as a non-parent (see section on custody and access).

The Ontario Law Reform Commission recommended in its 1985 Report that "upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes."¹⁴³

At least one commentator on the subject of whether the commissioning couple should be the child's presumed parents has argued that it is logical that the genetic/gestational mother not be considered to be the child's legal mother:

First, a female "donates" an ovum. Her act of "donation," for which service she may legally receive a fee, severs her legal relationship with that ovum. Second, the ovum is fertilized by a known sperm donor who has affirmed his intention to become the legal father of the resultant reproductive product. Third, the female donor allows the resultant embryo to be implanted in her uterus (a separate "service" for which she should theoretically also be allowed a fee). Fourth, the subsequent formal adoption of the child by the male sperm donor's wife establishes a legally binding relationship, just as the male's consent does in the AID context.¹⁴⁴

Although the law retains the principle that the child can have only one legal mother, in the event that she presumptively loses that title in favour of the social or commissioning mother, the genetic/gestational mother would have the burden of overcoming the presumption of maternity before she could prove that it is in the child's best interests to remain in her custody. This situation is not directly parallel to the situation where donor sperm is relied on and the husband of the recipient is presumed to be the child's legal father. The sperm donation is analogous to the situation where a woman relies on donor ova she gestates herself. The termination of parental rights takes place at the time of the donation, before the gestation of the child. The role of gestation is of too much significance to permit it to play no role in the attribution of maternity.

Where a commissioning couple relies on a genetic/gestational mother and on sperm donated by another man, the situation becomes even more complex. Added to the difficulty facing the intended mother of the child is the complete absence of a genetic link with the intended father. The only method of placing the intentional parents in the position of legal parents is by way of adoption.

(c) *Lesbian Couples*

In a situation where two women living in a lesbian relationship decide to start a family relying on donor insemination, there can be several potential problems with the attribution of maternity.

1. Where one woman of the couple contributes ova and the other contributes gestation, the situation is somewhat different from that previously described where there is a split between genetic and gestational motherhood because, from the outset, *both* women intend to parent the child. Our legal system will not currently permit them both to be legal mothers, and yet there is no clear solution as to which of them should take precedence. While the family remains together, the actual legal attribution of maternity need not necessarily be an issue.

If the couple decides to split up, unless they can come to some amicable agreement as to the custody of the child or children, there will be significant problems in determining which of them should be the legal mother. Once that decision is made (on whatever criteria the court determines are appropriate) the next step is to decide which of the two should have custody of the child. The decision on the first issue is obviously critical to the decision on the second.¹⁴⁵

In the above situation, should the conventional presumption of maternity operate, rendering the gestational mother the legal mother of the child, the ovum contributor may be denied parental status. Although this will not automatically preclude the "second mother" from obtaining custody, it certainly does not lend her any assistance.

Further problems or complications would arise where a known sperm donor was relied on. If he attempted to establish his paternal rights, the court would have to deal with three potential parents and a serious problem of intent. Which of the parties intended to parent the child and at what stage was the intention made manifest? Was there a change of heart? At what stage? Is intention relevant to the attribution of parental status?

If maternal filiation is established on the basis of gestation rather than genetics, and if a child is legally precluded from having two female parents, the ovum contributor would not be a legal parent of the child in the above situation. Therefore, in a custody battle with a sperm donor who had established his paternity according to current legal principles, the ovum contributor would be making a case as a non-parent against a parent or potentially against two parents.

2. Where one woman acts as genetic/gestational mother using donated sperm, the woman who acts as genetic/gestational mother will conclusively be the child or children's legal mother, regardless of the role the other woman plays in the family (e.g., even if the non-biological mother functions exclusively as the homemaker and the principal

caretaker of the child or children and mother while the second woman is the breadwinner). For the non-biological mother to be able to make her case in relation to the child, she will have to rely on legal doctrine permitting a legal stranger custody or access to the child or children in question.

(d) *Maternity and In Vitro Fertilization*

The issue of the legal attribution of motherhood has been complicated further by the possibility of pregnancy with a donated ovum. As a result of the technologies of reproduction, it is now possible to separate and isolate the three distinct biological components of procreation: contribution of sperm, ova, and gestation. The relative values of each of the components may be a determining factor in the right to parent the child born of the divided functions. Several combinations and permutations are possible.

The manner in which many issues related to the use of donor embryos or gametes and to the actual status of the embryo are resolved will have an impact on what happens to the issues of filiation and when filiation is established. These issues are of fundamental importance to the creation of a coherent and cohesive approach to legislation in the area of the NRTs, and the issues relevant to them are complex.¹⁴⁶

Where a woman relies on IVF to become pregnant, the following combinations are possible:

1. The sperm and the ova come from the couple who wish to bear the child.
2. Donated ova/embryos are relied on; the genetic mother is different from the gestational mother.
3. The intended social parents rely on another woman to gestate their own genetic offspring (i.e., the "surrogate mother" is merely a gestational mother rather than a genetic/gestational mother).
4. A woman is "hired" to gestate an embryo created for the commissioning couple, but which is not genetically related to the couple or to the gestator.

The attribution of maternity in these situations can be highly complex. Historically, we have no precedent on how to deal with the divided function. In addition, the issue of intention as a basis for parental rights has the potential to complicate seriously the attribution of parental status.

1. Where the sperm and the ova come from the couple who wish to bear the child and the woman of the couple gestates the embryo.

Filiation is clear in this situation: legal parenthood corresponds directly with genetic parenthood.

2. Where ova/embryos are donated, the genetic mother is different from the gestational mother, but the latter also intends to parent the child.

In this situation, the present presumption of maternity would make the gestational mother the legal mother of the resulting child. In some ways, this situation is similar to that of sperm donation, where the donor's rights and obligations are terminated at the time of the donation. The intention of the gamete donor to terminate all parental rights and obligations at the time of the donation is reflective of an intention not to parent the resulting child. Furthermore, and perhaps more importantly, once the intention is established, the relationship between the gametes and the donor is completely severed. In this situation, the woman who gestates the embryo (comprising donated ova and perhaps even donated sperm) does intend to parent the resulting child, and the donor has no more to do with the process.

While at present in most Canadian jurisdictions there is no formal stipulation that a sperm donor renounces all his rights and obligations for the child to be born of his sperm, that renunciation stems from the protection of anonymity guaranteed to the donor.¹⁴⁷

Where there is no legislation confirming the right of donors to terminate their parental ties at the time of the donation, the potential remains for the donor to seek to establish legal rights in relation to the resulting child. Should there be no law to the contrary, there would be nothing to stop the ova donor from attempting to establish her filial link with the child born of her genetic material, as there would be nothing to stop any other interested party from establishing the same.

Where an ova donor wished to attempt to prove her maternal link with the child born to another woman, she would have to take the action almost immediately after the child's birth to prevent the establishment of possession of status, the relationship between the child and his or her "acting" parents.

In France, when necessary, the courts will recognize the possession of status as commencing during the prenatal period.¹⁴⁸

The law on this is different in Quebec, although recently the existence of a maternal relationship between the mother and the infant before birth has been recognized.¹⁴⁹ This factor is of particular importance in Quebec, where the possession of status is given statutory weight; however, even in other jurisdictions, it would be unlikely that a court would give precedence to an ovum donor over the gestational mother, particularly if the latter had had an opportunity to establish a social link with the child by retaining the child for a period after the birth.

Most law reform reports and many commentators have recommended that the woman who gestates the child should be the child's legal mother, thus upholding the *maxim mater est quam gestatio demonstrat*, which has been the cornerstone of our law in this area.¹⁵⁰

An exception is made in some of the reports or legislation, which recommend that when a genetic/gestational mother gives birth to a child, the intentional parents would automatically acquire legal parental status.¹⁵¹

3. Where the intended social parents rely on another woman to gestate their own genetic offspring (i.e., the "surrogate mother" is merely a gestational mother rather than a genetic/gestational mother).

In this case, the issue of the extent of the gestational mother's rights becomes relevant. Is the existing presumption of maternity, which is based on gestation, the most appropriate presumption? It is also important to bear in mind the effect of deciding that that presumption is most appropriate in the situation where donor ova are relied on, and to consider whether there should be an exception built into it to meet the needs of this kind of gestation arrangement. This may not be an issue if a jurisdiction takes the position that contracts for gestation are absolutely null and unenforceable, such as in Quebec's Bill 125.

Setting aside the question of enforceability, the woman who gestates the embryo in this scenario is not genetically related to the embryo and did not, at the outset, intend to raise the resulting child. She agreed, before implantation, not to seek parental status of the child she would subsequently carry. Should she later decide that she does not want to give up the child, there is some question as to whether her contribution of gestation and birth should take precedence or whether the genetic mother's contribution and initial intention to parent should take precedence. This becomes more complicated when the intentional mother is neither the gestational nor the genetic mother (i.e., where a woman has acquired an embryo or an ovum from another woman with the intention of creating a child for herself to raise).

As the law exists today, the presumption of *mater est quam gestatio demonstrat* would prevail as a basic presumption; however, it may be possible for that to be rebutted. In all jurisdictions where there is *prima facie* evidence that another woman is the child's genetic progenitor, a court would likely entertain an application for a declaration of maternity based on the genetic link between the child and the woman.

In at least two U.S. decisions, the gestational mother has been held to have no rights with regard to the baby she bore for an infertile couple, where the baby was genetically linked to the commissioning couple.¹⁵²

In the California case of *Anna J. v. Mark C.*, the commissioning couple contributed both the sperm and the egg, and the resulting embryo was subsequently implanted in a gestational mother. Before the birth, the gestational mother decided not to give up the child and attempted to retain her parental rights over the child. The commissioning couple sought custody. The court relied on the results of a blood test to conclude that the gestational mother was not genetically related to the child and therefore could not be recognized as the child's natural or legal mother. The court awarded parental status to the sperm and ova contributors. In its decision awarding custody to the commissioning couple and depriving the gestational mother of any parental status or rights, the court applied a paternal standard to determine the issue of maternity, relying on *genetics* as the determining factor.

Le Conseil du statut de la femme de Québec refers to the child in these circumstances as having two mothers, for no matter what the juridical norm, the reality is that the biology of reproduction counts for something that cannot be ignored.¹⁵³

It is highly unlikely that in a case where the surrogate has been in possession of the child for a period of time, a court would oblige her to surrender the child to the social parents. In contrast, when the surrogate is a single woman who cannot prove her genetic links with the child, in the interests of the child the court would likely allow the social parents to take the child.¹⁵⁴

4. Where a woman is “hired” to gestate an embryo created for the commissioning couple, but which is not genetically related (1) to the couple or (2) to the gestator.

In the first of these situations, a commissioning couple who is incapable of producing the gametes for the production of an embryo are recipients of donated gametes or a donated embryo. They then hire a gestational mother to carry the embryo to term and give birth to the child. This is a true “gestational mother” situation, complicated by the fact that not only does she have no genetic link with the child, but neither does the commissioning couple.

In this case, whose rights take precedence — the gestator’s or those of the intentional parents? Does it or should it make a difference if one of the members of the commissioning couple contributes gametes? In the absence of genetic contribution, what right does the intentional mother have to the child she plans to parent? If her spouse has not contributed sperm to the resulting child, neither of them has the genetic link that is normally the method of establishing rights in this context. The gestational mother may have the only legally recognizable tie with the child. It is difficult to say whether the courts could create some right in the commissioning couple in view of their intention at the outset to be the parents of the child.

Adoption

When an intended parent cannot establish legal parenthood by proving a presumed, a biological, or a genetic link with the child, the only other alternative available under our current law is for the intended parent to adopt the child.

Under the law of adoption, the link between an individual and a child is based on a legally attributed title rather than a physiological link. The only basis for the parental relationship is the intention of the adopting parents; the child’s biological parents have generally decided to consent to the termination of their parental rights quite apart from the decision of the adopting parents to assume responsibility for the child. The distinction between the situation of individuals adopting a child under the existing law and the situation that arises when a child is born of assisted reproduction is significant.

In the first place, a child who is adopted under the traditional adoption law is conceived, presumably by accident, by way of natural intercourse. The woman carrying the child decides, at any time during her pregnancy or at any time after the birth, that she cannot or does not wish to parent the child, and she offers the child up for adoption. Once that preliminary decision has been made, it is possible for adopting parents to be made aware of her intention and to prepare for the possibility of parenting the resulting child. Formal consent to the adoption cannot be given by the child's legal parents until the child is born and in most jurisdictions is at least four days old. Even after the initial legal consent is granted, the parents have a right to revoke it, within statutorily defined limits.

In contrast, where a child is born as the result of the intention of individual(s) who are not genetically linked to him or her, that intention is clearly manifest before conception. Whoever participates in the creation of the child knows from the outset who it is intended will parent the resulting child.

Traditional adoptions are child rescue operations, not palliatives for disappointed parents. The current adoption system allocates lives in being; the child is already in a crisis. In short, adoption poses the least detrimental alternative for the child. In marked contrast, the host mother in a surrogate parenting contract conceives the child intentionally for the very purpose of exchanging the child for money. Rather than centering on the needs of a child, the surrogate model exists primarily to satiate the psychic and financial needs of adult parties. Rather than providing a postconception solution to a fortuitous pregnancy, the surrogate model inaugurates a birth that will culminate in separating a child from its gestational and genetic mother. The resulting child may experience not only the sense of rejection and isolation that are the occasional unavoidable by-products of an orthodox adoption, but also a sense of worthlessness as a human being because its natural mother calculated his or her worth in dollars.¹⁵⁵

When examining the adoption legislation to determine whether it is an appropriate mechanism for regulating the filiation of children born as a result of the NRTs, two situations must be explored:

1. one of the child's intentional parents can establish a biological link with that child, and the adoption process is for the legal benefit of his or her spouse; and
2. there is no genetic link between the social parents and the child, and the individuals wishing to have legal parental status have commissioned the child's birth, but neither has a genetic link with the child.

Step-Parent Adoption

As we have described, the step-parent adoption laws are for the purpose of facilitating the formalization of the relationship between a child and the spouse of the child's legal parent. The rule permits the adoption of a child by the spouse without affecting the existing relationship between

the legal parent and the child. Before such an adoption procedure can be undertaken there must be a termination of the legal parenthood of the child's other legal parent, by way of death, consent, or a determination of unfitness or abandonment.

The existing law on step-parent adoption was created to deal with situations where the legal parent of an existing child enters a new relationship with a legal stranger to the child, and that stranger wishes to assume the full parental role for the child. In those cases, the child has usually been born (as opposed to being *in utero*) at the time adoption is contemplated.

In the context of AHR, the step-parent adoption provisions are most commonly contemplated in the context of genetic/gestational motherhood when the child's biological father is one part of the commissioning couple and his spouse is the would-be step-parent. There must be legal transfer of the child from the gestational mother to the intentional mother. At present there is no method of presuming the parental status of the intentional mother. This is in contrast to the ease with which a child born of donor insemination (using sperm from the intentional father) can be incorporated into the family of his or her intentional father.

When a genetic/gestational mother becomes pregnant in order to produce a child for the commissioning couple, the man who contributes sperm (the child's natural father) and the would-be step-parent (the natural father's spouse) plan the birth of the child; from the outset they both intend to parent the child. On the other hand, the child's other natural parent (the genetic/gestational mother) intends, even before she becomes pregnant, to consent to the termination of her legal parental rights. In fact, whether legal or not, what she does is give her consent before the implantation.

One commentator has distinguished the genetic/gestational mother situation from that of adoption in three ways: first, unlike adoption, "a surrogate makes the decision to give up the child in advance of conception at a time in which she can make an informed, unemotional reflection about whether she wants to bear a child for another couple." Second, the conceptus carried by a gestational mother would not exist but for the commissioning couple's decision to enter into a surrogacy arrangement. Finally, in a surrogacy situation, "the man wishing to rear the child is the child's biological father."¹⁵⁶

If the genetic/gestational mother fails to adhere to her agreement to consent to the termination of her parental rights, the intended social mother would have no legal claim to the child.

It is interesting that because of the existence of the two-parent rule (meaning a child can have only one legal mother and one legal father), the intention of the spouse of the child's legal father to rear and parent the child does not give her any legal right to the child. This is in direct contradiction to the principle upon which the spouse of a woman who gives birth to an AID-conceived child is attributed legal parenthood. The reason

for the distinction is presumably the significant role that gestation plays in the creation of a human being (substantiated by the rule of public order that prevents a woman from being bound by a pre-birth agreement to terminate her parental rights). Is the intention of the commissioning mother any less significant than that of the AID father? Should that intention play a role in the attribution of parental status?

No Genetic Link Between the Commissioning Couple and the Child

This situation would arise when a couple relied on a genetic/gestational mother to bear a child for their benefit, and the gametes used were not those of the would-be social parents. This situation is more akin to traditional adoption, but for the intention of the commissioning couple. It is clear from the outset that the child is brought into the world for the benefit of the commissioning couple, and "but for" that intention, the child would never have been born.

Existing Canadian law would require that this child be adopted by the commissioning couple through the normal adoption laws. The absence of a presumed or genetic link to the child would mean that without recourse to the law of adoption, they would have no legal right to the child whatsoever. This means that should the genetic/gestational mother wish to revoke her consent to the termination of her parental rights, she could do so, making adoption of the child by the commissioning couple virtually impossible.

Where private placement adoptions are not permitted, such as in Quebec, the commissioning couple would have an extremely difficult time obtaining legal custody of the child.

Revocation Period

When a child's legal parent consents to that child's adoption by another, there are two significant time frames. The first, as we have described, is the time that must pass after the birth before consent to the adoption becomes legal. The second is the period after the initial consent has been given within which that consent can still be successfully revoked. (See subsection on "Issues of Consent.")

Because consent to the termination of parental rights is given in the genetic/gestational motherhood situation before the commencement of the pregnancy, it is difficult to make a direct correlation between the regulation of adoption and of preconception arrangements.

If a contract for genetic/gestational motherhood is legally recognized, there are several possible methods of dealing with the issue of consent. One might consider the preimplantation consent absolutely binding, so that no period of revocation is permitted once the genetic/gestational mother is pregnant. Alternatively, such a preimplantation consent may be recognized, but the woman may be given a period of time after the birth within which she can legally revoke that consent, much along the lines of the adoption legislation, provided that, once that time has elapsed, no further revocation is possible (as the child will, by that time, have been placed with

the intentional parents). The commissioning couple will have more or less security in their parental intentions, depending on how binding consent is, and what right there is to revoke it.

When examining models for legislating genetic/gestational motherhood, we would be wise to examine carefully the rationale for permitting a somewhat extended period for revocation, as is the case with adoption. A study of the psychological impact of adoption on both parent and child, and the incidence of revocation, would also be enlightening. The differences between adoption and genetic/gestational or gestational motherhood should not be ignored.

Screening for Fitness

Another issue relevant to the application of the adoption model to this area is whether or not it is appropriate to screen recipients of donor gametes or embryos. Applicants for adoption are screened for their suitability to parent, and, in most provinces, such screening may be undertaken even in the case of a step-parent adoption.

At present, reliance on donor gametes does not invoke screening of the couple in any formalized way. When couples are unable to procreate naturally, the "achievement of parenthood requires the assistance or intervention of third parties."¹⁵⁷ Once third-party involvement occurs, the desire of a couple to become parents is not spontaneously facilitated. Instead, the third parties, the state, judges, lawyers, physicians, and social workers will often assist only those couples (or individuals) *they think* will make fit parents. Despite the absence of formal screening criteria, the fact that there is third-party involvement means that there will be some level of informal screening. Screening of this nature can easily result in inequality of access to assisted reproduction. Where financial capacity, race, ethnic origin, etc. can influence those providing the services, concern for the child's welfare may not be the paramount consideration.

Access to Records

The final parallel to be drawn between the adoption model and the situation of children born as a result of AHR involves the principle of anonymity and the right to access records. Historically, it was deemed more appropriate to keep an adoptive child from knowing his or her natural parents. The social link between the child and the adoptive parents was intended to supplant totally the relationship between the child and his or her genetic progenitors. In this way, there could be no confusion about the family to which one belonged.

Subsequent to that early approach to adoption, there has been a growing movement in favour of disclosure of information about an adoptive child's genetic parents.¹⁵⁸ This movement was commenced largely by adoptees wishing to know about or to contact their natural parents. The present law, as we have seen, generally permits such contact to take place within a regulated framework.

When approaching the issue of gamete donation, the tendency has been to presume that anonymity of donors is appropriate. Where there is no regulation to the contrary, it is not uncommon for sperm banks to retain no nominative information on donors. This means that, although a file may consist of certain genetic information and perhaps some social information about the donor, there will be no way of supplementing that information in the future.

Many commentators are critical of donor anonymity. Le Conseil du statut de la femme de Québec has stated the following:

Furthermore, the anonymity of sperm donors has grave consequences, since it deprives the child of the right to know his biological origins. And, since the donor cannot be clearly identified, it prevents the detection of hereditary diseases that could be transmitted by the sperm.¹⁵⁹

Le Conseil recommends that legislation be passed that clarifies the right of a child, at the age of majority, to know the identity of his or her natural parents. In addition, it recommends that at the age of 14 these same children be given, on request, a summary of their antecedents (with no identifying information), and that their adoptive parents be given the summary on adoption.¹⁶⁰ This would bring the rights of children born of AID in line with those of children who are adopted.

With regard to children born with the help of technology, the Conseil du statut de la femme [du Québec] (Quebec council on the status of women) sees an urgent need to adopt specific provisions in order to avoid these children having no relationship of parentage other than a legal one. Indeed, the anonymity of sperm donors, ovum donors and surrogate mothers means that at the present time it is not possible to identify the genetic and biological origins of the children procreated in this way.¹⁶¹

The right to know one's origins has been considered as significant as the right to privacy: it touches on a person's identity and the integrity of the person.

It has been argued that

[w]hile a strong argument in favor of permitting offspring to know or learn their genetic and gestational heritage can be made, the law has progressed slowly in making such information available to adopted children. Because collaborative offspring will be born before this issue has been definitively settled, it is important that records be kept, so that offspring might have access to them at a later time if public policy or the original parties later permit access.¹⁶²

One of the critical factors in favour of the preservation of identifying records on donors is the growing importance of genetic information to people at various stages in their lives (as our ability to screen for genetic conditions becomes more sophisticated). Furthermore,

Wadlington reports that a "study concluded (in 1979) that there was little effective genetic screening of donors in the sample. Family histories usually were superficial, and biochemical testing was rarely done.

Inadequately trained physicians performed most screening ... Less than twenty-nine percent of the respondents conducted biochemical tests on donors aside from blood typing, and the major purpose of such testing was to detect communicable diseases ... The study confirmed that the degree of record keeping, particularly with regard to donors and children conceived by AID, is minimal.¹⁶³

If the objective of the law maker in this area is to protect the best interests of the child, it would appear that the maintenance of thorough records, including identifying information, would be appropriate.

To preserve anonymity and to deny the psychological importance of having a genetic history will not preserve and protect the family structure. In this age of changing biological realities, the family may be best protected by considering carefully how best to protect the interests of all parties involved rather than the form of the family itself.

The Legal Parental Relationship

A determination of the legal parentage of children born through use of assisted procreation techniques is critical for both the children and those who have contributed to their birth. The attribution of legal parentage affects the rights and obligations of the parties involved with respect to custody, access, support, and inheritance.

Parental Rights Doctrine

Historically, the parental rights doctrine has operated to ensure that the natural parents of a child maintain custody of their child from birth. There has been an assumption, in law, that custody of a child should automatically be vested in his or her natural parents.¹⁶⁴

Today, the doctrine of parental rights operates to preclude the court from intervening with the parents' right of custody of their child except in particular and extreme circumstances and in accordance with the due process of law.

In conjunction with the automatic right of custody of the child, legal parental status also confers specific rights and obligations on parents. In particular, parents are responsible for the day-to-day care and control of a child and are entitled to make decisions about the educational, medical, and religious aspects of a child's life. They are also responsible for providing necessities of life, including physical, financial, and psychological care. In general, while the parental rights doctrine operates to protect legally the rights of parents to custody of their child and to fashion a relationship with their children free of state interference, the state does, nevertheless, impose duties and obligations on parents to provide for the care and well-being of their children.¹⁶⁵

While it is a well-established social principle that parents have a right to raise their children in accordance with their own views and practices, and that the natural family surroundings are the best place to ensure that the child's welfare is protected, the state does retain power pursuant to its role as *parens patriae*¹⁶⁶ to take measures to ensure that children receive a minimum standard of care tolerable in our society. Therefore, while the state has a compelling interest to preserve and promote the welfare of children, the state will not interfere with the functioning of a family until it has been demonstrated that a child's welfare is compromised by his or her parents because they are unwilling or unable to provide the child with a minimum standard of care. Even upon a determination that a child is not adequately cared for, the state will often allow parents to retain custody of the child under state supervision.

There is a strong belief in our society that even though children may have a greater material advantage and perhaps even better care in the custody of someone else, children are still better off residing with their parents than with strangers or government agencies. (See subsection "Contests Between a Legal Parent of a Child and a Non-Parent," *infra*.)

Upon a determination that a child's welfare is compromised in the care of his or her parents, parental rights can be limited or terminated. However, it must be stressed that the termination of parental rights other than by consent of the legal parents is possible only upon a finding of parental unfitness or abandonment.

Custody and Guardianship

Historically, the concept of guardianship was broader than that of custody and included, among other things, the care, supervision, and maintenance of the child; the right to make decisions about the child's education and medical care; the right to consent to the marriage of the child; and the right and obligation to protect and manage the property of the child and custody of the child. Custody was one incident of guardianship and referred to the actual physical possession of the child. However, the concept of custody has expanded to include the broad range of rights and obligations formerly associated with guardianship.¹⁶⁷

In recent decades, the distinction between guardianship and custody in Canadian jurisdictions has become blurred, and in some Canadian jurisdictions the concepts have been merged altogether so that no distinction is made between the two. However, in several Canadian jurisdictions a distinction remains, preserving important variations among provinces and territories, some of which could have a bearing on the determination of custody and guardianship cases involving the children born as a result of assisted procreation. Unless otherwise specified, in this paper the term "custody" is used broadly to include more than simple physical possession of the child.¹⁶⁸

In most cases, a dispute about custody arises between the legal parents of a child as a corollary to divorce or separation proceedings, or when the legal parents of the child have never been married (whether or not they have ever cohabited) and, living in separate homes, each wishes custody of the child. However, the question of custody sometimes arises between a parent and a non-parent.

Historically, at common law, the father of a legitimate child had a *prima facie* right to guardianship and custody of his child, and there existed no basis upon which the child could be removed from his custody.¹⁶⁹ As there was no recognition of the juridical personality of a woman separate from that of her husband, it is obvious that the legal custody of legitimate children would rest with their father. Upon the death of the father, the mother of the child became the guardian of the child. However, in the case of illegitimate children, the mother was the sole guardian and custodian of the child, and the male biological progenitor had no rights or obligations. In the nineteenth century, under the English Lord Talfourd's Act, the Court of Chancery began to give married women rights of access to their legitimate children and physical custody when the child was under the age of seven years. However, these rights were contingent upon the mother not committing adultery.¹⁷⁰

By the twentieth century, the preference for maternal custody of children of "tender years" became entrenched in Canada as the "tender years doctrine." Essentially, this doctrine operated to guarantee mothers the custody of their young children in the event of a custody dispute between parents, on the grounds that a child up to the age of seven years needed the care of the mother more than that of the father. However, if, for example, the mother were found to be unfit or even unsuitable, custody would be awarded to the child's father. When the tender years doctrine was originally advanced, it was understood that the father retained full rights of guardianship while relinquishing custody. One of the effects of this doctrine was to place the burden of child-rearing responsibilities onto the mother while the father retained decision-making power with respect to the child. Recently, any automatic legal preferences for granting custody of young children to one parent over another have been modified. The view in every Canadian province and territory is that the welfare and best interests of the child are the paramount issues in the determination of an award of custody between the child's legal parents.

Principles Governing an Award of Custody

In every Canadian province and territory, the paramount principle in the determination of an award of custody is the "best interests of the child" or the "welfare of the child."¹⁷¹

In most provinces, the legislation enumerates specific factors that the court must consider in determining the best interests of the child. These factors include the following:

- (a) the mental, emotional, and physical health of the child, including any special needs or treatment;

- (b) the love, affection, and similar ties that exist between the child and each person to whom the child's custody is entrusted, any members of the family who will reside with the child, and other people involved in the care and upbringing of the child;
- (c) the length of time the child has lived in a stable home environment;
- (d) the views and preferences of the child where those views and preferences can be ascertained;
- (e) the ability and willingness of each person applying for custody of the child to provide the child with guidance, education, the necessities of life, and any special needs of the child;
- (f) any plans proposed for the care and upbringing of the child;
- (g) the permanence and stability of the family unit in which it is proposed the child will live (i.e., the home environment);
- (h) the ability and willingness of each person seeking custody of the child to act as a parent; and
- (i) the relationship by blood or through an adoption order between the child and each person who is a party to the application.¹⁷²

The Supreme Court of Canada has made it clear that the determination of the "best interests test" is to be done from the standpoint of the child, not the parents. Madame Justice L'Heureux-Dubé wrote:

By focussing on the welfare of the child, the legislatures and the courts now consider the best interests of the child from the standpoint of the child and not from the standpoint of the parents.¹⁷³

Although the best interests test is the formal legislated grounds for resolving a custody dispute, this test is applied in conjunction with the parental rights doctrine described above. The basic presumption is that it is in the best interests of a child to live with his or her natural parents.

As a result of the combination of these two doctrines, there is a distinct difference between a custody dispute between two legal parents and that between a parent and a non-parent.¹⁷⁴

Contests Between the Parents of a Child

Guardianship

In all Canadian jurisdictions, mothers and fathers have equal rights of guardianship, except in Alberta, British Columbia, New Brunswick, and the Northwest Territories, where the fathers of children born outside a legally sanctioned marriage have not been accorded the same rights of guardianship as mothers. Generally, in these provinces the father of a child born outside marriage does not have equal rights of guardianship unless he has cohabited with the mother of the child for at least 10 months before the birth of the child. In the absence of the requisite period of cohabitation, the mother will be the sole guardian of the child unless otherwise ordered by the court.¹⁷⁵

Custody

In most jurisdictions, legislation exists that provides that both parents are equally entitled to the custody of their child. There is no presumption from the outset that one parent has a greater right to custody than the other; any sex-based distinctions for awarding custody have been eliminated. Therefore, in a custody dispute between the legal parents of a child, the factors that have been set out above will be applied in making a custody determination between them that is in the best interests of the child.¹⁷⁶

In most jurisdictions, the equal entitlement of both parents to the custody of their child extends to both the mother and father of a child born outside marriage, so that the mother has no *prima facie* right to custody of the child over the father where the couple has never married (where legal paternity has been established). Even in the provinces that retain the status of illegitimacy, the words "parent" or "father" in statutory provisions setting out who may apply to the court for custody of a child — who has standing — have been held to apply to the father of an illegitimate child, thereby removing the legitimacy/ illegitimacy distinction in the context of custody.¹⁷⁷

In two jurisdictions, where the parents have never cohabited before or after the birth of the child, the child's mother is his or her sole guardian or custodian.¹⁷⁸

However, such provisions do not preclude the non-custodial parent from applying to the court for custody of the child and from exercising his or her entitlement to custody. It must be emphasized that although both parents have an equal right to custody of their child, the court will frequently award sole custody to one of the parents with access to the other, after considering all of the relevant facts of the case and upon a determination of which parent is best able to ensure the welfare of the child. Therefore, upon an award of sole custody in favour of one parent, the other parent, while retaining a *right* to custody of the child, will be deprived of the exercise of that right: he or she may reapply to the court for a variation of the custody order.

With increasing frequency the Canadian courts are granting joint custody, such that legal custody is shared between the child's legal parents. In most Canadian jurisdictions legislation directly permits a court to grant custody to one or more persons.¹⁷⁹ The federal Divorce Act and the Children's Law Act in Saskatchewan each includes express provision that a child should have as much contact with each of his or her parents as is in his or her best interests.¹⁸⁰ The legislation in the Yukon goes so far as to create a rebuttable presumption of joint custody.¹⁸¹

Joint custody clearly has two different aspects: one is joint legal custody, such as that presumed by the Yukon law; and the other is joint physical custody, where the responsibility for the day-to-day care of the child shifts from mother to father (week by week, month by month, etc.). An order for joint physical custody is unlikely unless the parents of the child have agreed to it and can make it work. Orders for joint legal custody

tend to be more common. Where this is the case, both parents, each retaining custody while one retains day-to-day care and control, will retain the right to participate in major decisions regarding the child (such as those relating to medical care, change of school, etc.).¹⁸²

Contests Between a Legal Parent of a Child and a Non-Parent

In custody disputes between a parent and a non-parent, the non-parent must first have standing to appear before the court to make an application for custody of a child to whom he or she is a legal stranger. Generally, any person who is not the legal parent of a child will be subject to a different and more rigorous standard in proving that the child's interests would be better secured in his or her custody. In addition, the non-parent will be required to satisfy the court of his or her legitimate interest in bringing the custody application in the first place. Such measures protect parents from frivolous challenges to the exercise of their custody rights while permitting non-parents, who may have acted as de facto parents to the child, to obtain or retain custody of the child when it is in the child's best interests. In most jurisdictions in Canada each parent has a right to apply for custody, as does any other person or those persons specifically entitled by statute.¹⁸³

In the 1950s, a trilogy of Supreme Court of Canada cases established a rule stipulating that in a custody dispute between the parent of a child and a non-parent, the natural parent had a right to custody of the child unless he or she had abandoned the child or, in the opinion of the court, had conducted himself or herself in such a way that it would have been improper for the child to remain with that person.¹⁸⁴

The predominance of a natural parent's right to the custody of his or her child has been altered since the 1950s, with an increased importance being placed on the child's best interests. While there is no absolute formula applied to determine custody disputes between a parent and a non-parent, Mr. Justice McIntyre of the Supreme Court of Canada set out the most important issues in the 1985 case of *King v. Low* as follows:

[T]he dominant consideration to which all other considerations must remain subordinate must be the welfare of the child. This is not to say that the question of custody will be determined by weighing the economic circumstances of the contending parties. The matter will not be determined solely on the basis of the physical comfort and material advantages that may be available in the home of one contender or the other. The welfare of the child must be decided on a consideration of these and all other relevant factors, including the general psychological, spiritual and emotional welfare of the child. It must be the aim of the Court, when resolving disputes between rival claimants for the custody of a child, to choose the course which will best provide for the healthy growth, development and education of the child so that he will be equipped to face the problems of life as a mature adult. *Parental claims must not be lightly set aside, and they are entitled to serious consideration in reaching any conclusion.* Where it is clear that the welfare of

the child requires it, however, they must be set aside (emphasis added).¹⁸⁵

The weight of the parental rights doctrine permitting parents to retain custody of their child does remain intact, although somewhat altered from the early years, with the courts taking greater care to assess the child's best interests. There can be no question that the courts frequently confirm that residing with a natural parent is in fact in the child's best interests. Mr. Justice Wakeling expressed it this way in the Saskatchewan Court of Appeal case of *Hardcastle v. Huculak*:

Now all things being comparatively equal the welfare of a child is best served in the custody of one or both of his natural parents; there is the advantage of natural parental and filial love, of extended natural family relationships, and of the sense of security which comes from knowing, and knowing of, one's family and one's roots.¹⁸⁶

In referring to the Supreme Court's decision in *King v. Low*, Conant J. in *Clapp v. Morin* confirms that

the courts regard a child's relationship with its natural parent as being in its best interests unless the other needs and circumstances of the child require that the child be removed from the natural parent ... in my view the paramount consideration in a custody dispute is the best interest of the child, an important factor of which is the child's ties to his natural parent.¹⁸⁷

In Newfoundland and Ontario, one of the factors taken into consideration by the court in determining the best interests of the child is the existence of blood ties between the child and his or her parents. However, it has been suggested that this right is grounded in the right of the parents to retain custody and is not solely based on the best interests or welfare of the child.¹⁸⁸

In a recent Quebec case, the Supreme Court of Canada held that it need not find any wrongful behaviour on the part of the parent to award custody to a non-parent. However, as set out in the judgment in *C.(G.) v. V.-F.(T.)*, the court states that the non-parent seeking custody of the child must rebut the presumption that the parent is in the better position to ensure his or her child's welfare, and the non-parent must establish, on the balance of probabilities, that the child's development will be compromised by remaining in or returning to the custody of the parent. Finally, the non-parent seeking custody must demonstrate that she or he is able to provide the care and affection required by the child.¹⁸⁹

It is our view that this case clarifies the relationship between the best interests of the child test and the parental rights doctrine by establishing a method for determining when the exercise of custody rights of a parent can be abrogated in favour of a legal "stranger." The court states that there is a presumption that the parent of a child is entitled to the custody of his or her child vis-à-vis any non-parent, and that it is in the best interests of the child to remain in the custody of his or her parent. However, this pre-

sumption may be challenged by a non-parent. In the event of a challenge, the non-parent must rebut the presumption by proving, on the balance of probabilities, that the child's development will be compromised in the custody of the parent and, in addition, must demonstrate that she or he can provide the care and affection that the child requires. The Supreme Court, in this case, has adopted a lower threshold than unfitness or abandonment for depriving a parent of the custody of his or her child in a contest with a non-parent.

The Supreme Court emphasized that a parent could not be deprived of the exercise of his or her custody vis-à-vis a non-parent simply because the third person was "better off financially, better educated or because he or she already has other children."¹⁹⁰

In cases where custody has been awarded to a non-parent over a parent for reasons other than unfitness or abandonment, there is almost always a well-established relationship of day-to-day care and affection between the child and non-parent. It has been the view of the court that to remove the child from a stable and nurturing home and to place him or her in the custody of a parent with whom there has been little or no social relationship is not in the child's best interests.¹⁹¹

Access

Access by Parent

As in the case of custody, the standard used to determine whether a parent will receive access, and the terms of that access, is the best interests of the child. The law on the natural parent's right of access was summarized by Boisvert J. in the recent case of *Theriault v. DeHaitre*:

A child has a right to peace and security. From his parents he can expect a flow of love and affection. On the other hand, parents are expected to provide the care and affection required by the child. However, there is no parental inherent right of access which exists simply because someone happens to be the natural parent. The idea that parents have proprietary rights and dominion over children is no longer true.¹⁹²

Typically, access is regarded as a right of the child.¹⁹³

There is a view that a child's right to access with the non-custodial parent stems from his or her right to the affection and influence of two parents and the right to establish and sustain a relationship with two parents:

Children are part of a family. They have two parents and have a right to be influenced in their upbringing by each of the two parents. They have a right to the affection of each of the two and while divorce may dissolve the marriage it does not dissolve the parenthood and the court must be careful not to continue a prohibition against visitation rights except in the most exceptional cases.¹⁹⁴

Even when a parent has not visited his or her child for years, the court has concluded in some cases that contact between the child and the parent is in the child's best interests.¹⁹⁵

The rights of a parent with access are more restricted than those of the custodial parent. Although custody entails the responsibility of caring for the child and making life decisions with respect to the child, including those about education, medical care, and religious training, the access parent enjoys rights of visitation and a right to be informed about the health, education, and welfare of the child, but cannot interfere with the general upbringing of the child unless otherwise ordered by the court.¹⁹⁶

Access by Non-Parent

In most jurisdictions, people who are not parents may apply to the court for access.¹⁹⁷

However, a non-parent's application for access is not likely to succeed unless that person has a strong, pre-existing relationship with the child or the custodial parent approves of the access arrangement. The onus, in such cases, is on the non-parent to demonstrate that access would be in the best interests of the child.¹⁹⁸ In addition, the courts are also concerned about the extent to which access by the non-parent might undermine the relationship the child has with his or her parent.¹⁹⁹

Support

In every Canadian jurisdiction, the parent of a child has a statutory obligation to provide financial support for his or her child. In some jurisdictions, the word "parent" is defined to include not only the mother and father of the child but also the child's grandparents. In addition, in several jurisdictions the word "parent" includes a person who has demonstrated a settled intention to treat the child as a child of his or her family where there is no biological connection between the "parent" and the child (a *de facto* parent). In every jurisdiction, if the mother and father of a child are unmarried, the father continues to have an obligation to support his child. This obligation exists even when he does not cohabit with the child, and even when he has no rights of access to the child. Moreover, even in those jurisdictions where the distinction between legitimacy and illegitimacy is preserved, the biological father of a child has an obligation of support if his paternity is established.²⁰⁰

Legally, there is no relationship between a parent's right to access and his or her obligation of support. Denial of access does not affect a parent's support obligation.²⁰¹

Commentary — Custody, Access, and Support

AHR gives rise to complex disputes over the custody, access, and support of children so born. When a dispute arises as to which of a

number of competing individuals should have custody of a child, the most important first step is to determine legal parenthood.

As we have seen, the impact of legal parenthood and the parental rights doctrine on issues of custody and access is significant, and, despite the legislated requirement that these and other like matters be decided in the best interests of the child, the parental rights doctrine has tended to enshrine a presumption that it is in the child's best interests to remain with his or her legal parent(s). In a dispute between a legal parent and a legal stranger, the decision is definitely weighted in favour of the former. A strict adherence to these rules is becoming increasingly difficult as the courts are obliged to deal with situations where the attribution of legal parenthood is no longer so easily made, and where more than two individuals have a "legitimate" claim to parent the child. The notion of competing interests of different individuals is not new to family law in general and custody disputes in particular; however, the complications added by the potential split between biological, genetic, and intentional parents that arise in the context of AHR are new.

One of the main reasons AHR introduces such difficulties to settling these disputes is that they are likely to occur before any one of the parties has had an opportunity to establish a relationship with the child. Much of the legal reasoning on the resolution of these kinds of "battles" is based on a situation in which the relationship of a heterosexual couple has broken down sometime after they have given birth to and raised a child together for a period of time. The intention of both parties in relation to the child has been tested in the time they have functioned together. The resolution of the question of what is in the child's best interests can be based on an assessment of the relative relationships and other life circumstances of the competing parties. Although unquestionably subjective, this assessment can, at least to some extent, be experientially based. When the situation arises in the context of AHR, the contest will frequently be between people who have had no prior relationship (i.e., the donor and the recipient, the commissioning couple and the genetic/gestational or the gestational mother). The dispute will arise before or immediately after the birth of the child, and any relationship that develops between any one of the parties and the child will be under the shadow of highly contentious litigation.

In Canadian jurisdictions, it is difficult to anticipate how disputes about custody, access, and support in the various situations made possible by assisted procreation will be resolved. In this section we explore some of the possible situations in which such disputes may arise and the tests that will likely be used to resolve them.

Rights and Obligations — AID

As we have discussed earlier, the use of AID raises questions with respect to both the status of the AID-conceived child and the parental status of the sperm donor. A further complication arises with respect to the intentional parents of a child born of the NRTs who do not have a legal parental relationship with the child.

In our commentary on the law of filiation, we discussed the method of determining the legal relationship between a sperm donor and a child resulting from his donation. We have also established that on the basis of a defined legal parental status, or where there is an existing parent-child relationship, an individual has a right to seek custody of or access to a child. (The inverse is also true; where there is a legally established relationship, support can be sought from the non-custodial parent.) The success of any such action will be based on the relationship between the competing individuals and the best interests of the child.

Sperm Donor

For the sperm donor who wishes to seek custody of or access to "his" child (if he can locate that child) there are obstacles if the mother is married or living in a stable heterosexual relationship. In this sort of situation there are two hurdles the donor must clear: first, he must rebut the presumption of paternity that exists in favour of the mother's spouse; second, he must establish that ruling in his favour would be in the best interests of the child.

Although the determination of paternity generally rests on genetics, the courts have not always applied a strict biological standard for determining who should be the legal father of a child. It could be argued successfully that the intention of the donor to sever his parental rights at the time of the donation should, even in the absence of legislation permitting and enforcing it, be enough to permit the court to sever the parental tie between the donor and the child. In this case, the intentional parent would be granted the legal status of parent, and the donor would lose his standing with regard to the custody dispute because he would be a legal stranger to the child, having no legal parental status and usually no social relationship with the child.

Single Woman and Known Donor

An additional issue with respect to the rights and obligations of sperm donors vis-à-vis an AID-conceived child is that involving a single woman who is inseminated with the sperm of a known donor and does not want the donor recognized as the legal father of the child or granted any of the corresponding parental rights or duties. Under current law, the sperm donor would have no presumed right as legal parent of the child born of his sperm. He would likely be permitted to apply to the court for custody or access by establishing his relationship with the child. The converse of that is the woman's right to pursue the known donor for child support, a right the present law grants her.

In at least two U.S. cases, sperm donors have successfully established their paternity of an AID-conceived child and were granted visitation rights. They were also ordered to pay child support. In *C.M. v. C.C.*, an unmarried woman inseminated herself with the sperm of a man she had known for approximately two years and with whom she had been contemplating marriage; the relationship broke off before the child's birth.²⁰²

The court held that although conception was achieved through AI, the circumstances of the insemination supported the conclusion that the sperm donor had consented to the insemination and to the responsibilities of fatherhood. In addition, the court held that it was in the best interests of the child to have a father, and the sperm donor was the only person situated to take this role.

In *Jhordan C. v. Mary K.*, a lesbian woman inseminated herself with the sperm of a known donor. When the child was born, the sperm donor sought custody of the child. Although he was denied custody, he was awarded visitation rights as father of the child. Although California has legislation providing that when the semen of a donor is used to inseminate a woman other than the wife of the donor, he will be treated in law as if he were not the natural father of the child, the court held that the legislation applied only when the insemination was performed (as provided by statute) by a licensed physician and not when the woman had inseminated herself. Therefore, in the absence of compliance with the statutory requirement, paternity was determined in the ordinary way and visitation rights and support obligations were awarded.²⁰³

While the ostensible reason for declaring the paternity of the semen donor in *Jhordan C.* was non-compliance with the statutory provision that the semen be provided by a licensed physician, some authors have suggested that other factors may have influenced that court's decision.²⁰⁴

In situations such as this, where a known individual is relied on to provide sperm to a single woman, it could be argued that there is lack of clarity between whether it is the "contribution" of sperm or the "donation" of sperm. The distinction between the two terms lies in the intention of the man giving up the sperm. In the former situation, it is not clear that he intends to have no parental relationship with the child; in the latter, the process of donation involves an absolute termination of all rights and responsibilities to and for the child. It has been suggested that if no other man is filling the role of father for the child (e.g., where the mother is single or is a lesbian), the courts have conferred paternal status on the sperm donor because they have deemed it in the best interests of the child to have two parents, one of each sex. Also, in many situations where the donor is known, the court can infer from the pre-existing relationship between the donor and the recipient that he intended to contribute to the birth of the child; thus, there was no unequivocal termination of parental rights and obligations.

Anonymous Donor

When a single or lesbian woman is inseminated with the sperm of an anonymous donor, she is almost certain not to have her parental intentions thwarted, as the identity of the male genetic progenitor will most likely be unknown. The child born in this circumstance will then have only one legal parent. Disputes over custody, should they arise, will inevitably be between a parent and a non-parent.

Spouse of Biological Mother of Child Born of AID

When a married woman or a woman living in a "stable heterosexual relationship" has a child by AID, her spouse may or may not incur responsibility for the child or rights to parent the child. If the husband was fully aware that the child was conceived by way of AID and, during the life of the relationship between the child's mother and himself, treated the child as his own, he will likely be held responsible for child support.²⁰⁵ However, if he did not consent to the insemination and has no knowledge of the circumstances of the child's conception, it is probable that no settled intention to treat the child as his own will be found. Consequently, no child support obligation will be imposed on him.²⁰⁶

Within this context, it is interesting to note that, in the dispute between mother and "father," the interests of the child may not actually be paramount. Consideration of the "father's" right to know of and consent to the donor insemination is clearly giving protection to his rights. To what degree the child's interests should predominate is a question worthy of consideration.

There is some question as to a man's liability for support payments when the couple separates before the birth of the child and the husband subsequently contests paternity to evade child support obligations. In this case, would the courts take into consideration the circumstances surrounding the child's conception as a demonstrated settled intention to treat the child as his own? It is submitted that to protect the best interests of the child, this is precisely what would occur (or they would rely on some other reasoning to obtain the same result). Bill 125 in Quebec settles this matter by stipulating, in article 540: "A person who, after consenting to medically assisted procreation, does not acknowledge the child born of such procreation is responsible to the child and to the mother of the child."

AID Relied on by Lesbian Couple

Finally, an issue arises as to whether the lesbian partner of a woman who has given birth to an AID-conceived child is able to assert parental rights or incur parental obligations with regard to the child if she has cared for and supported the child (the same arguments could be used in relation to homosexual male couples). In the British Columbia case of *Anderson v. Luoma*, the court dismissed the application of the plaintiff for child support and would not impose parental responsibilities on a lesbian woman for the AID-conceived children of her former lesbian partner. In this case, the women had cohabited for 10 years and the applicant had two children by AID. During the relationship, the defendant supported the plaintiff and the two children. When the relationship ended, the plaintiff sought support for the two children.

The court held that "the Family Relations Act does not purport to affect the legal responsibilities which homosexuals may have to each other or to children born to one of them as a result of artificial insemination."²⁰⁷

According to the court, the act applies to the "spousal and parental relations of men and women in their role of husband, wife and parent." Neither the definition of parent nor the definition of step-parent in the legislation included the respondent. The court adopted a conventional, heterosexual conception of the family and inferred that the two parents of a child must be one male and one female. By so doing, the court limited the children's entitlement to support to their legal (and genetic/gestational) mother only, thereby depriving them of the opportunity for two lines of support. The court was unwilling to impose the parental obligation of child support on the lesbian partner in the absence of a filial link.²⁰⁸

The doctrine of *in loco parentis* exists for the benefit of an individual who voluntarily provides support or takes over custodial duties for a child or children who are not legally his or hers. The typical situation in which this arises is a step-parent arrangement where the step-parent has acted in the place of a parent but has had no right to adopt or simply has not done so. The early Saskatchewan case of *Shtitz v. C.N.R.*²⁰⁹ sets out the basis of the rule of *in loco parentis*:

A person *in loco parentis* to a child is one who has acted so as to evidence his intention of placing himself towards the child in the situation which is ordinarily occupied by the father for the provision of the child's pecuniary wants. In vol. 22 of the Cyclopaedia of Law and Procedure, at p. 1066, the following definition of the phrase *in loco parentis* is given:

"When used to designate a person it means one who has put himself in the situation of a lawful father to a child with reference to the office and duty of making provision for the child."

The *in loco parentis* doctrine is at present a relevant factor in determining the maintenance obligation of a step-parent on divorce or on separation. The Canadian Divorce Act stipulates that, within the act, "child of the marriage" includes:

- (a) any child for whom they both stand in the place of parents; and
- (b) any child of whom one is the parent and for whom the other stands in the place of a parent.²¹⁰

The rights and obligations of the individual who is acting *in loco parentis* are contingent on a factual analysis of the actual relationship. The Canadian courts have not permitted an extension of the doctrine to render both spouses equal in relation to "children of the marriage." For the most part, reliance is put on the doctrine to ensure that an individual acting *in loco parentis* and providing support to the child or children will continue to be responsible to pay support even after the breakdown of the family.²¹¹

A reading of U.S. case law dealing with the resolution of custody disputes arising between a legal parent and a legal stranger reveals some doctrinal principles relied on to get around the impact of the parental rights

doctrine. There can be no question that in a variety of different circumstances, the strict application of the parental rights doctrine is not in the best interests of the child. The U.S. courts have relied on the following principles to get around the weighty parental rights doctrine: (1) equitable parenthood, (2) equitable estoppel, and (3) *in loco parentis* similar to the doctrine in Canada.

Equitable Parenthood

Equitable parenthood is a doctrine that was first framed in the Michigan case of *Atkinson v. Atkinson*.²¹² The court held that

[A] husband who is not the biological father of a child born or conceived during the marriage may be considered the natural father of that child where (1) the husband and the child mutually acknowledge a relationship as father and child, or the mother of the child has cooperated in the development of such a relationship over a period of time prior to the filing of the complaint for divorce, (2) the husband desires to have the rights afforded to a parent, and (3) the husband is willing to take on the responsibility of paying child support.²¹³

Although the court in this case did not refer to the rights of the child's biological father, it granted the social father the status of "natural father," thus granting him the same rights as he would have had if he had been the child's legal father. It has been argued that the fact that the couple, in this case, was married when the child was conceived and born would make it distinguishable from those situations where the family into which the child is born is an "alternative family form," such as one headed by a lesbian couple. The interesting point is that the court did not grant the social father his rights based on the presumption of his paternity, but rather on the three-pronged test outlined above. Each of the elements of the test could be met by other types of relationships and by a traditional nuclear family.²¹⁴

Equitable Estoppel

Equitable estoppel is a doctrine that developed as an equitable remedy to prevent someone from enforcing a right that he or she would otherwise have had a right to enforce:

The effect of voluntary conduct of a party whereby he is precluded from asserting rights against another who has justifiably relied upon such conduct and changed his position so that he will suffer injury if the former is allowed to repudiate the conduct.²¹⁵

It requires (1) action or non-action by one party that induces (2) reliance by another to his or her detriment. This doctrine has been used by the courts in the context of an application for support from a non-parent. It would apply in a situation where a woman, with the tacit consent of her partner, conceives a child by way of AID. After the child's birth, the woman's partner decides to renege on the agreement to assume responsibility for the child. The child's mother, when applying to the court

for support from her previous partner, could not establish his paternity for the child (in the absence of consent legislation); however, she could attempt to prove that she relied on the promise of support from her partner before receiving the donor insemination and that she never would have become pregnant in that manner but for the agreed-upon support of her spouse. Thus, she has relied on his stated promise to her detriment. On the basis of this evidence, the absent partner would be estopped (prevented) from denying his obligation to pay support.²¹⁶

The doctrine has also been used in a limited number of cases to allow a non-parent to maintain a relationship with a child despite the absence of a legal tie. "Once a jurisdiction holds that estoppel can require a legally unrecognized parent to pay child support, both doctrinal coherence and equity compel courts to recognize corresponding rights of custody and visitation."²¹⁷

The need to rely on this type of doctrine stems from the pre-eminence of the parental rights doctrine, which presupposes that the legal tie with the child is the most significant determining factor in granting the rights and obligations of parenthood.

This same commentator refers to two cases of courts having relied on this doctrine: in cases where a lesbian couple has jointly raised a child or children and, on separation, where the non-legal parent has successfully sought joint custody.²¹⁸

Functional parents — including lesbian parents — may develop a parent-child relationship in several ways. A lesbian-mother family can hold itself out as including two mothers. It can treat a child as part of both mothers' extended families. A child can have the last names of both mothers. The child's birth announcement can list two mothers. A legally unrecognized mother can contribute to the child's financial support and the legally recognized mother can accept such payment ... Under any of these circumstances, the legally unrecognized mother should be able to seek the legal status of parent. She should be permitted to assert that by creating the parent-child relationship and representing that child rearing was a joint endeavor, the legally recognized mother has been estopped from denying the functional parent the status of legal parent.²¹⁹

Where legislation is unclear or non-existent with respect to the parental status of the various parties who are the biological progenitors of an AID-conceived child, or who acted socially as a parent to the child, confusion will inevitably arise about their respective parental rights and obligations. Perhaps more than anyone, it will be the AID-conceived child who will suffer the most from the protracted legal battles to resolve the various custody, access, and support issues, and from the emotional strain that may result if the issues are legally resolved in a way not in accordance with the child's sense of his or her family.

Rights and Obligations of Genetic/Gestational Mother

There can be substantial problems for a commissioning couple if a genetic/gestational mother refuses to consent to the termination of her maternal rights. In this situation, the courts have tended to rely on the existing legal definitions of parenthood, according maternity to the genetic/gestational mother and paternity to the biological father (there is a problem in those jurisdictions where consent legislation creates an irrebuttable presumption in favour of the genetic/gestational mother's spouse). Having made this determination, the court then addresses the issue as a custody dispute between two legal parents.

A fascinating issue relating to the resolution of custody in the context of preconception arrangements is that even where the actual contract for the services of the genetic/gestational mother is held to be unenforceable, the courts have recognized the apparently equal rights of each biological parent to seek custody. One commentator noted that as a result of the final decision in the *Baby M* case,

A commissioning party in New Jersey now purchases a chance. If the surrogate performs the contract, the commissioning party may pay the contract price and receive a child. If the surrogate balks, the purchaser has a chance to secure the child through a custody action. And if the commissioning party is deemed a parent, he has at least as good a chance of winning primary custody as if he had married the mother of the child. Indeed, his chances may be better. The trial judge may well identify and [sympathize] more with the father than with the surrogate.²²⁰

The fact that the commissioning biological father contributes sperm to the genetic/gestational mother with the intention of parenting the resulting child distinguishes him from the sperm donor, who arguably loses all rights to the resulting child. This is so even if he has no relationship with the mother of the child either before the insemination or during the pregnancy (and presumably even if he has never met her). The basis for his right to parent the child and to compete with the biological mother for custody is that he intended to parent the child from the outset and his genetic material contributed to the creation of the child.

At least one commentator has argued that the initiation of the genetic/gestational motherhood arrangement by the natural father and his wife with the intention of producing a child that they can raise is sufficient to render this father different from other fathers who seek parental rights before establishing a relationship with the child. The anticipation and expectation of fatherhood in this case, she argued, can be equated directly to the expectation of the natural mother.²²¹

Best Interests of Child Test

The legislation regarding the determination of which of two or more competing individuals should have custody of a child stipulates that the decision must be rendered on the basis of the best interests of the child.

The application of the best interests of the child standard in the context of a custody dispute arising from AHR is problematic. Typically, custody disputes arise between the parents of a child as a corollary to divorce or separation proceedings. In such cases, both have established a parental relationship with the child who is the subject of the custody dispute. In almost all cases when the court is called upon to resolve an issue of custody, it will enquire not only about the future circumstances within which the child will be raised, but also about the past and present circumstances and relationships that have shaped the child's life. As reflected in the various statutory factors that the court is instructed to consider when determining the best interests of the child, decisions about the future well-being of the child are, in part, intimately connected with the care, relationships, and affection the child has had in the past.

Although custody decisions based on the best interests of the child test are ostensibly forward-looking, based on the court's assessment of the optimal placement to promote the future welfare of the child, in making its determination the court can rely only on the past and present life circumstances of the various parties.

In the context of conventional custody disputes, the best interests standard has been criticized by various commentators for its inherent indeterminacy.²²² Not only must decision makers divine the future if they are to assess the prospects of the child's placement options, they must also adopt a set of values to be able to interpret the meaning of the best interests of the child.²²³

It is not surprising, therefore, that the application of the best interests of the child test in a custody dispute between two fit parents tells us less about the welfare of the individual child involved than it does about prevailing social norms, judicial biases, and psychological theories regarding the kinds of families in which children should live.²²⁴

In addition, although the rationale behind the best interests of the child standard is to secure the welfare of the child, it is questionable whether the practical application of this standard achieves its aim. Because of its indeterminacy, respective parties seeking child custody will often litigate the dispute, attempting to marshall evidence to prove to the court that each is and will continue to be the better parent of the child. Costly, adversarial, and protracted adjudication is rarely in the best interests of the child.²²⁵

Although the application of the best interests of the child standard is problematic in conventional child custody cases, it is even more so in custody disputes arising out of contract motherhood arrangements. First, because the custody dispute will take place over a newborn or infant child, the court will have little evidence upon which to base its award of custody. With the exception of the period while the child is *in utero*, neither legal parent will have had much of an opportunity to establish a relationship with the child, and neither will have demonstrated his or her parenting skills. For the most part, any inquiry into the determination of the better parent for the infant child will be speculative, and, in the absence of many

substantive facts, a court is likely to rely upon personal or class bias in reaching a decision.²²⁶

As several commentators have noted, the class differences between the commissioning couple and the genetic/gestational mother are apt to be much greater than in the case of a separating or divorcing couple. This financial inequality may not always exist, but it is prevalent enough to be a cause of concern.²²⁷

The disparity in wealth may lead many judges to conclude that in a dispute between two fit legal parents, it is in the child's best interests to award custody to the parent with material advantages. Also, as suggested by one commentator, a disparity in social class may lead to very different parenting styles and aspirations; both judges and those providing expert testimony will, because of their common social class, identify with the plight of the commissioning parents.²²⁸

In addition, it has been argued that the decision of a genetic/gestational mother to enter into a contract is baby selling or abandonment, and that she should therefore be refused custody of the baby; the natural mother's willingness to enter into a contract is evidence of her intent to abandon the child. She has therefore demonstrated her intention to relinquish all rights to the child.²²⁹ This argument raises many further counter-arguments about the degree to which such intention can be found to compromise the rights of the parties. An anticipatory renunciation of parental legal obligations is not valid since the duty to maintain one's children is a duty of public order.

Ethical and Social Issues

From a purely legal perspective, the advent of the NRTs has introduced fascinating problems: creative litigators acting on behalf of one party or another can have a "field day" attempting to create new law by analogy to the old. Unfortunately for law makers, they cannot align themselves with one case and assume one perspective on these issues. It is vital that the law acknowledge social morality, and that includes encompassing as many perspectives as possible; in the context of the new technologies, this is no easy feat. Law and policy makers must weigh the merits of numerous perspectives, some of which are directly at odds with others, to establish a baseline for our society. In this section, we explore some of the different issues that have a direct bearing on the position taken with respect to many of them.

It is critical to remember, before we begin this section, that the NRTs are not relied on for the birth of most babies. Decisions made to accommodate these "new" families stand to have serious implications for all of our legal families. In reassessing our legal structure with a view to facilitating the attribution of parental status and the rights of custody, access, and support within the context of the NRTs, it must be acknowledged that our

social reality is changing in other ways, making it necessary to examine the other new forms of family as well.

One of the primary functions of family law is the regulation of social relations. These relations are dynamic, whereas the law is a relatively static force. Therefore, for a law to function effectively, it must reflect social reality and thus keep pace with social change. Unfortunately, because of the static nature of legislation and the difficulty of regulating social issues by way of legislation, the law of the family often reflects an era gone by. At a juncture such as this, when we question and assess some of the foundations of our laws, we may find that many social principles enshrined in the existing legal structure do not reflect present reality adequately.

The “Traditional” View of the Family

From the time of early industrialization our law has reflected a view of the family as a social unit comprising one mother, one father, and children, living together in a nuclear family arrangement. This family structure is viewed as the norm and is more than adequately represented in media depictions of family life. It is also reflected in the legal structure that defines the family as a unit. This “norm” exists despite the variety of family structures found in the many ethnic and Aboriginal communities in our society.

To maintain this view of the family and to confirm that our society is best served with a baseline of family law that recognizes the nuclear family as the only legitimate family structure is certainly an option for legislators, although the impact of recent challenges by gay men and women will be unavoidable. As we have noted earlier, as a rule, the law is not relied upon in the private relations of the family until such time as a dispute arises. In this way, alternative family forms and alternative processes for bringing children into the world by private arrangement will continue to function, but with the law turning a “blind eye” to their presence and refusing to recognize them should access to the court be sought for dispute resolution.

The dominant value in our society that married couples should have and want children draws considerable impetus, support, and legitimization from the fact that all of the major religious groups interpret procreation as a moral obligation necessary for fulfillment of the religious ends and purposes of marriage.²³⁰

Our Western religious inheritance includes a notion of the family that is triadic. These three elements are deemed to constitute the core of the family: (1) there must be marriage between the biological parents; (2) there must be unconditional parental loyalty; and (3) the child to be born must be an end in himself or herself (rather than a means).²³¹

Within this strict formula lies the basis for our notion of the most appropriate structure for the family. Heterosexual marriage is, from the perspective of many, an important first criterion for the commencement of a family; the family unit is thus tied together before God and the state.

Reproduction of the human species is not to be lightly undertaken, and, when a new life is conceived, it is incumbent on the child's natural parents to assume their respective responsibilities for that child:

Procreation is understood in the Catholic tradition as more than merely transmitting life to a child, rather it is understood to mean both giving biological life to and rearing the child to maturity. Having given life to the child, the parent has the duty and the right to rear it.²³²

Finally, the ultimate objective of reproduction is the creation of a child. That child must be the focus of the reproductive process. The process itself as a means to another end is a misappropriation of reproduction: when a natural mother enters a contract with a view to producing a child for another in exchange for financial benefit, the basic tenet of the child being the end rather than the means is violated. The same violation results from the commissioning couple who are prepared to exchange money for the right to parent a child born to another woman.²³³

The traditional model of the family functions by way of linking the genetic progenitor of a child with the responsibility for that child. Should a parent refuse to take an active interest in the nurturing aspects of parenting, the law will see to it that the parent cannot absolve himself or herself of the financial responsibility that goes along with the creation of a human life. Should both natural parents decide to forfeit their respective parental rights and responsibilities, the law will facilitate the termination of those rights in favour of their assumption by another individual or couple, by way of legal adoption. The ideal model for adoption is once again the nuclear family. The inherent value of natural reproduction and the maintenance of natural bonds of the family are jeopardized by the NRTs; they have introduced a potential shift in responsibility of each individual for the product of his or her reproductive capacity.

Although the ideal of the nuclear family comprising a woman, a man, and their natural children remains the epitome of the legal family, "the common law has been slowly moving away from exclusive emphasis upon the biological family as the norm, and towards a limited acceptance of the concept of the 'social' family."²³⁴ The context within which the debate on the NRTs arises is one where the traditional notion of the family is losing some ground to the reality of the new social families.

To a large extent, the law on the family can preserve its traditions even in the face of AHR. It is possible to permit the spouse of a woman who is inseminated by way of donor sperm to be the legal father of the resulting child. It is biological fiction perhaps, but, where a spouse has consented to the procedure, it is not a flagrant contravention of our social or cultural norms. When the genetic material is donated by a third party, there is no monetary exchange debasing the notion of the child as an "end in itself" rather than a means to an end. The couple raising the child need not share the reality of the child's birth with anyone; the reliance on donor sperm can be a secret, and thus the nature of the family structure will not be visibly

different from that of the traditional nuclear family. The same can be said of ova donation and even embryo donation (although there is an increased chance of visible detection should the child be so different from the recipient couple as to belie the fiction).

However, a significant problem arises in the context of "surrogate motherhood" — what we have referred to more specifically as genetic/gestational or gestational motherhood. By introducing a third party into the reproductive process, a person who is significantly more involved in the process than a gamete donor, there is a shift in the structure of the family.

Unlike the situation of donated gametes or embryos, the reliance on a gestational or a genetic/gestational mother is not so easily absorbed into our traditional view of the family. The fact that the child born of the genetic/gestational mother is the result of a contractual relationship between the biological parents contradicts the basic presumption of our family structure — that you are born to the status of family member. (Adoption serves a separate function in that it is for the benefit of the child; the contract for childbearing is for the benefit of the commissioning couple rather than the child.) This shift from status to contract as the basis for a family relationship poses deep problems, as it reflects a fundamental change in the way we view family relations.²³⁵

Hired maternity impairs the order of these fundamental relationships. At a minimum, the state must, therefore, withhold its enforcement mechanism from use as an instrument effectuating such arrangements. This the law has traditionally done, by treating contracts impairing familial relationships as unenforceable and void as against public policy. The law of marriage and family, grounded as it is in equity rather than contract, ought to remain the exclusive legal matrix for a constitutive order of domestic relationships in the domestic sphere.²³⁶

This same commentator argues that domestic relations have traditionally been governed by the norms inherent in the human moral significance of sexual and procreative relationships. He suggests that two alternative paradigms for regulation of the family are possible competitors with the traditional one: "(1) the autonomous intention of the individual, under liberal individualism; and (2) positive conferral by the state, under theories giving overriding importance to the sovereign command of government."²³⁷ He argues that

if the normativity of the intrinsic structure of sex and procreation is sacrificed as the basis for formulating rules on legally cognizable marriage and domestic rights and duties, in favor of one of these stated alternatives, either the market or the state can be expected to invade the sphere of intimate human relations, ultimately at devastating human cost.²³⁸

To maintain the traditional view of the family as the only legally recognized family unit would require either a strict restriction on access to donated gametes or an acceptance of donated gametes in the context of a

heterosexual couple in which both parties consent to the assumption of the parental rights and responsibilities resulting from the birth of a child. The latter solution would permit the continuation of the nuclear family model while allowing those who have not been able to have children to fulfil their parental ambitions. The invasion of the private sphere by state regulation could be kept at a minimum and the status quo maintained more or less successfully, provided that gestational and genetic/gestational motherhood was strictly limited.

Within this model, the reliance on contract for the production of a child for rearing purposes would be totally unacceptable. Such contracts would have to be unenforceable at the very least.

Alternative Family Forms and Their Challenge to the Status Quo

Legal recognition of the family structure affording protection to its members was initially granted only to married couples. Within recent decades, a substantial amount of that recognition has been extended to heterosexual couples living in stable relationships. For those heterosexual couples wishing to be afforded the full recognition of the law, there is always the option of legal marriage.

More recently still, same-sex couples living in stable relationships have questioned the rationale for preventing them from having the same protection the law grants to heterosexual couples living "common law," or in fact from the right to marry.

In January 1991, leave to appeal to the Supreme Court of Canada was granted in the case of *Canada (Attorney General) v. Mossop*.²³⁹ This was a case regarding the definition of "family status" in the Human Rights Act. A homosexual had sought the right to bereavement leave after the death of his partner's father. He was denied the leave on the grounds that his partner was not family. The Federal Court of Appeal held that defining "family status" as excluding homosexual relationships did not constitute discrimination prohibited under the act. The matter was appealed to the Supreme Court of Canada and judgment was rendered on 25 February 1993. In his decision on behalf of the majority of the Court, Mr. Justice Lamer ruled that, because the appellant argued the issue on a strict statutory interpretation of the Human Rights Act as it existed in 1983 and did not raise a Charter challenge, the Court could do nothing but dismiss the appeal.²⁴⁰

In December 1992, a homosexual couple living in Ottawa, having been refused a marriage licence by a Justice of the Peace, sought recourse to the courts for the right to marry under Canadian law.²⁴¹ The matter was heard by a three-judge panel of the Divisional Court of Ontario, who rendered a majority decision on 15 March 1993 upholding the decision of the Justice of the Peace not to issue the licence. Mr. Justice Southy stated for the majority that the purpose of marriage is the founding and maintaining of a family in which children will be produced and cared for. "That principal

purpose of marriage, as a general rule, cannot be achieved in a homosexual union because of the biological limitations of such a union." In dissent, Madam Justice Susan Greer stated that a refusal to grant marriage licences to homosexuals amounts to discrimination and as such constitutes a breach of the equality guarantees of the Charter.²⁴²

On 1 December 1992, the Federal Court of Appeal handed down a landmark ruling in the case of *Douglas v. The Queen*.²⁴³ This case concerned a lesbian woman who, as a member of the Canadian Armed Forces, was stripped of most of her rights once the fact that she is a lesbian became known to her superior officers.²⁴⁴ According to a provision of the Canadian Armed Forces Administrative Order, "Service policy does not allow homosexual members or members with a sexual abnormality to be retained in the CF."²⁴⁵

Ms Douglas challenged the prohibition against homosexuals in the military on the grounds that it constituted discrimination contrary to the *Canadian Charter of Rights and Freedoms*.²⁴⁶ The matter was settled, without going to trial, on the terms that Ms Douglas had been denied her rights under section 15(1) of the Charter, and that the provisions regarding the service of homosexuals in the Canadian Armed Forces are contrary to the Charter.

Shortly after publication of the decision in the Douglas case, and more probably in response to the August 1992 decision of *Haig v. Canada*,²⁴⁷ Kim Campbell, then Minister of Justice, tabled Bill C-108, An Act to Amend the Canadian Human Rights Act, in the House of Commons. The main thrust of this proposed legislative amendment is to include sexual orientation as a prohibited ground of discrimination, thus extending the rights effectively supported by the Federal Court of Appeal in the Douglas case.

Having established that there should be no discrimination on the basis of sexual orientation, the bill goes further in that it includes a definition of "marital status" that expressly excludes same-sex relationships:

"marital status" means the status of being married, single, separated, divorced, widowed or cohabiting with an individual of the opposite sex in a conjugal relationship for at least one year.²⁴⁸

The bill has, at the time of writing this, only received first reading in the House; there is no telling whether or not it will become a part of the law. It is important, however, because it clearly sets out the view of the present federal government on the issue.

A Gallup poll in May 1992 found that 84 percent of Canadians felt that homosexuality was more acceptable than it had been 25 years ago; however, 61 percent of the same survey opposed marriages between members of the same sex.²⁴⁹

Taking a strong stand against same-sex relationships and not extending to such couples the rights of heterosexual couples will undoubtedly have an effect on any children living with same-sex "parents" on the breakdown of the relationship of the couple. While as a society we have the

power to negate these relationships by refusing to give them legal recognition, they are unquestionably part of our Canadian mosaic.²⁵⁰ The advent of the NRTs has introduced the real possibility of children intentionally born to these couples who will grow up with two "parents" in a stable same-sex relationship.

When we examine the law of custody, access, and support in relation to the NRTs, we must be careful to consider the best interests of the children.

Genetics/Biology or Intentionality

Although it would be possible to maintain the traditional nuclear family as our legal ideal, unless there is a strict ban on participation in any of the assisted forms of human reproduction, issues are bound to arise when individuals with competing interests seek the assistance of the courts to sort out their rights.

As we noted earlier, the advent of the NRTs has increased the potential number of individuals participating in the creation of a child: there may be two genetic progenitors (those who contribute sperm and ova), one gestational mother, and two intentional parents (the "commissioning couple"), or any biologically possible combination of these. The limit on the number of legal parents a child may have, and on their respective sexes, makes the attribution of legal parenthood a difficult task in any one of these situations. Policy makers must focus on which of the competing individuals should have the paramount right: should genetics be the determining factor? Should biology dominate genetics when a gestator is different from the genetic progenitor? Should the intention of the parties weigh in the balance? Should intention be the determining factor exclusive of genetics or biology, or tempered therewith?

Genetics

It is clear from the way our law is structured that genetic links are significant. We permit presumed parents to rebut their status on the basis of biological reality. We acknowledge the right of adopted children to seek out their genetic parents. And despite the fact that, in law, the adoptive parents are the legal parents of the adopted child, we do not refrain from referring to the genetic progenitors of the child as his or her "parents."²⁵¹ It is extremely difficult, if not impossible, to define conclusively what degree of importance genetics has in defining ourselves. How does genetics weigh up against the social aspects of the family? Is one actually more important than the other?

The fact that we do set so much store by the genetic aspects of parenthood is critical to how we proceed in the face of the new biological realities. If we decide that the only model for the family is two parents of the opposite sex, we can legislate a purely genetic basis for the attribution of legal parental status. This would require shoring up the rights of individuals to contest their filiation with a particular child on the basis of genetic tests.

It would also require a reversal of the presumption of maternity *mater est quam gestatio demonstrat*, so that genetics predominates over gestation.

Genetics Tempered by Intention

If we decide that genetics should not be the ultimate defining factor in the attribution of parental status, the adoption of laws affirming the intentional father's right and obligation to parent a child conceived by way of AID and born to his spouse would be appropriate. The issue of intention is then a critical factor in deciding whether the intentional father should be bound irreversibly to that responsibility: where he did not consent to the procedure he would not be so bound; where he did consent he has no way out of the responsibility. The same approach may be taken in the context of donor ova. We have already noted that the assimilation of donor gametes and embryos can be undertaken without too much alteration or challenge to our traditional model of the family.

Unfortunately, there is an insurmountable problem in circumstances where we must decide which of two competing women will be given the right to parent a child when one has contributed the genetic material and the other, the gestation of the embryo. In this case, the existing legal presumption works in favour of the woman who gestates the embryo. Simply to maintain current legal presumptions will unquestionably lead to problems when two such women compete for status. At a minimum, a decision must be made as to whether to overturn the existing presumption favouring the gestational mother so that the genetic mother would take precedence, or to formalize it.

If it is decided that the traditional family model comprising one mother and one father is to be maintained, then we have no choice but to assist the courts by providing legal presumptions of parenthood or by providing an entirely different basis for assigning rights and responsibilities for children. It may be that where two women intimately participate in the creation of a child, the defining factor of who becomes legal parent should be the intention of each woman before the commencement of the process. "There is no persuasive basis for a categorical preference for either a gestational or a genetic contributor to receive exclusive recognition as 'mother.'"²⁵² Although this may be true, to leave the courts with no direction will mean that the judiciary will be responsible, on a case-by-case basis, for defining the very nature of our families.

The Doctrine of Intent

The most significant change introduced to the reproductive process by the NRTs is arguably the creation of the "intentional parent." In natural procreation, there are two parties to the process, and often neither of them sets out with the intention of procreating. Before a child can be born from AHR, each of the parties to a collaborative arrangement must intend to participate in a particular way. "Although a reproductive act does not always involve an intent to create a child, the use of reproductive technology is an unambiguous indicator of intent."²⁵³ This means that a donor

of either sperm or ova intends that his or her genetic material be used for the family project of another. The donor does not intend to parent the child or to assume any of the responsibilities attendant on parenting. However, the recipients of the donated gametes intend to parent the resulting child, despite the lack of a genetic tie of at least one of the social parents. The child would not be born but for their intentions.

Likewise, a genetic/gestational mother intends, from the outset, to become pregnant and bear a child for the purposes of a commissioning party or parties. It is not her intention at the outset to parent the child or to assume any of the attendant rights and responsibilities of parenting.

The role that intention should play in these situations is difficult to assess. Depending on the stand we take with regard to the importance of genetics in the determination of legal parenthood, the importance of maintaining the two-parent rule, and the impact of the parental rights doctrine, the role that intention plays in parenting will be of varying importance.

If we adhere to a strict genetic determination of legal parenthood, intention will not be relevant, except in the context of adoptive parenthood.

If we temper the genetic basis of parental status so that we recognize the right of the spouse of a woman who conceives a child by way of AID to be that child's legal parent, his intention becomes critical to his parental responsibility. The consent legislation in Quebec, Newfoundland, and the Yukon recognizes the importance of the intention of the spouse in AID situations. The manifestation of the intention to parent the child so conceived by way of consent to the procedure binds the recipient's spouse to the child and renders his paternity for the child unchallengeable. The child's legal filiation is irrebuttable, even with proof of genetic ties with another person.

Although Canada has no comparable legislation with regard to ova donation, the drafting of similar legislation is clearly feasible. The child born to a woman having been implanted with donor ova (or embryo) would be the irrebuttable parent of the child. This, too, would be based on the relevant intention of the parties with respect to the child; the donor would wish to absolve herself of parental rights and responsibilities, and the recipient would wish to retain those rights.

However, difficulties surface in the context of "surrogate motherhood" contracts. The requisite intention of the genetic/gestational mother to terminate her parental rights and responsibilities (which she has due to her genetic and gestational link with the child or, arguably, simply from her gestational link with the child) must be set out clearly before the implantation. The contract for the process is contingent on this consent being given.

The U.S. jurisprudence on the role of intention in the new parenting arrangements is substantial, and there is an active debate as to whether intention alone should be enough to vest parental status in individuals, or whether there should be a compromise position taken that balances in some manner genetics, gestation, and intention.

Much of the debate in the United States in favour of a true intentionality doctrine is based on an argument that supports the right to procreate as a constitutional right.²⁵⁴ This particular aspect of the debate is of limited significance in the Canadian context at present. However, if we set aside the constitutional arguments, we can examine the merits of the arguments in favour of a purely intention-based attribution of legal parenthood.

AID

As we have noted above, the situation of donor sperm and intentional parenthood is settled somewhat in those jurisdictions having adopted consent legislation. Where consent is given, the spouse of the woman giving birth to an AID-conceived child is irrebuttably presumed to be the child's legal father. His intention to parent the child is manifest by his consent to the procedure.

Even in those jurisdictions not having adopted this or similar legislation, the matter of paternity may be settled by the courts in favour of the child's presumed father rather than an unknown donor.

However, where no consent is given and the child's presumed father successfully contests his paternity, the child will end up with no legal father. Should the donor be known, or his name be accessible, the donor could be established as the child's legal father. This is directly contrary to his intention in relation to the donation of sperm. He did not donate the sperm with the intention of having a child of his own.

In a situation where a lesbian woman gives birth to a child by way of AID, her intention may well be that she and her female partner assume the parental responsibilities together as a family. In this case, the law will still attribute legal maternity to only one of the couple (the one giving birth, generally) and the child will still be fatherless — opening the potential for paternity being established in the donor. This would, once again, be contrary to the intention of the parties at the outset.²⁵⁵

Genetic/Gestational Motherhood — Gestational Motherhood

The complexity of the issues increases substantially in the face of contract motherhood. In this case, there are potentially six individuals whose intention in relation to the child must be considered:

1. the ova donor — in a situation where the commissioning couple cannot provide the gametes, it is possible that they may seek out an ova donor who intends not to parent the child and who surrenders her rights at the time of the donation (e.g., an infertile couple wishing to have a child as genetically close to them as possible seeks ova donation from a family member to be implanted in a third-party gestator);
2. the sperm donor — much the same as above;
3. the gestational mother, who expressly intends to bear the child for the commissioning couple and who agrees before implantation to consent to the termination of her parental rights;

4. the husband of the gestational mother, who will be presumed to be the child's father (irrebuttably in some places if he gives his consent to the insemination) but who does not intend to parent the child;
5. the commissioning couple, each of whom may or may not have contributed gametes and both of whom intend from the outset to parent the child from birth.

As we have noted, despite their express intentions, the rights of the parties in relation to the child born of their actions under current law reflect more closely their genetic relationship than their intentional relationship with the child.

Where donor gametes are used, consent to their use and to the termination of the donor's legal relationship with the resulting child is given at the time of the donation, well before the birth of the child. No social relationship of any kind can have developed between the donor and the child who will ultimately result from the donation. In this circumstance, as we have noted above, the sperm donor and the ova donor are on the same footing (despite the more complex method of obtaining the ova). Current law may recognize rights and impose responsibilities on the donors when legal parental status can be established.

The gestational or the genetic/gestational mother expresses her intention at approximately the same time chronologically, in relation to the birth of a particular child, as does the sperm donor. However, her function in the process is substantially different from that of the simple gamete donor. Having consented to participate in the process, she then nurtures and gestates the child over the next 40 or more weeks. The law at present would protect her right to legal maternal status but would not necessarily protect her right exclusive of the right of the child's genetic father (or genetic parents for a solely gestational arrangement).

Proponents of the doctrine of intent argue that the contributors to collaborative reproduction should be bound by their consent. Because, it is alleged, they commence their negotiations, or make their decision to donate, free from adverse pressures and on an equal footing before the commencement of the process, they should be free to contract as they wish; "intentions that are voluntarily chosen, deliberate, express, and bargained-for ought presumptively to determine legal parenthood."²⁵⁶ The commissioning couple, it is reasoned, should have the automatic legal right to parent the child born as a result of their collaborative efforts. This would mean that the existing presumptions in the law would be overturned in favour of a presumption of paternity in favour of the social father, and a presumption of maternity in favour of the social mother, regardless of genetic contribution. "While all of the players in the procreative arrangement are necessary in bringing a child into the world, *the child would not have been born but for the efforts of the intended parents* (emphasis in original)."²⁵⁷

Where the intentional parents are presumed to be the child's legal parents from birth, the presumption may be irrebuttable or rebuttable on a balance of probabilities, depending on the approach taken. If rebuttable, the gestational mother could, in exceptional circumstances, rebut the presumption, but she would be seeking to regain rights to the child, not retain them, and the burden of proof would be on her rather than on the commissioning couple. Although this view conflicts with the maternal presumption in favour of the gestational mother and the existing presumption of paternity, it has been argued that genetic/gestational motherhood is significantly different from "natural" reproduction.

The fact that the initiating parents mentally conceived of the child and afforded its existence prior to the surrogate mother's involvement must be acknowledged along with the fact that the surrogate mother entered the arrangement as a third party, willing to assist the initial parents, and that her husband, if she has one, consented to the arrangement with the understanding that the child would not be his — either biologically, psychologically or legally.²⁵⁸

This same commentator argues that the mental component of intent, which is important in other areas of the law (i.e., contract law and criminal law), has never been significant in family law, and that in the present context it should be.

The mental concept must be recognized as independently valuable; it creates expectations in the initiating parents of a child, and it creates expectations in society for adequate performance on the part of the initiators as parents of the child.²⁵⁹

Another commentator proposes the following:

[L]egal rules governing modern procreative arrangements and parental status should recognize the importance and the legitimacy of individual efforts to project intentions and decisions into the future. Where such intentions are deliberate, explicit and bargained for, where they are the catalyst for reliance and expectations, as is the case in technologically-assisted reproductive arrangements, they should be honored.²⁶⁰

By failing to recognize the important role the commissioning couple plays in the process in favour of the biological or genetic role, it is argued that "parental rights have been damaged by misperceptions of parenthood."²⁶¹ According to this view, a biological bias does not acknowledge the significance of planning a birth and of the reliance placed by the infertile commissioning couple on the other collaborators in the process. To leave them with limited rights to parent the child would lend far too much weight to the biological basis of the notion of parenthood.

In contrast to the above argument, one commentator has noted that the contractual model of reproduction, which would permit individuals to participate in collaborative reproduction and to consent to the termination of their rights in favour of another on a contractual basis, "denies the complexity of reproduction as an affective and social experience as well as a biological one."²⁶² The surrogate mother cannot know in advance what her feelings will be. The nature of what is being contracted about or for is

qualitatively different from the conventional object of a contract. Contract relations are often associated with the realm of the marketplace and are entered into to facilitate commodity relations between strangers or individuals who choose to minimize their relationships. Exchanges between family members are more often gifts; “[g]ift exchange has the capacity to cement and to commit people to each other.”²⁶³ Commercial relations and exchanges between family members are not directly interchangeable.

The discomfort expressed by the many commentators who argue against an intent-based model for the attribution of legal parental status may be attributable to the shift from status to contract.²⁶⁴ Although the donation of sperm and ova may be acceptable, preconception arrangements involve too much of the actual social process of reproduction. In addition,

[W]e do not have ... a good way to determine the value of specific reproductive contributions or to weigh conflicts between contributors ... At the very least, to use sperm donation as a paradigm for workable contracts reflects inattention to the vast differences, emotional as well as physical, in the nature of various collaborative roles. Moreover, it masks inequalities between parties with respect to risk and benefit.²⁶⁵

Whether or not contracts for gestation are appropriate in our society requires much more close study.

Should we accept the principle of contracts for gestation? Can a model be created that preserves the positive elements of both status (traditionally attributed family relations) and contract relations and avoids the negative elements of each — one that “secures familial loyalties and commitments” while making possible “new options and freedom” and, at the same time, avoids treating human beings as commodities and viewing human relations as flowing exclusively from biological inevitabilities?²⁶⁶

Our understanding of the experience can perhaps be reinterpreted as Robertson suggests, so that what comes to count as reproduction is the donation of genetic material for one person, or the experience of gestation for another. Yet while there are very good reasons for preserving the freedom of individuals to choose their level of participation in procreation, to say that the meaning of reproduction can be reduced to one of these partial roles is to perpetuate an impoverished notion of what it means to be a parent. Assigning various rights and obligations to abstract roles may facilitate the execution of collaborative contract, but risks treating the various components of reproduction as though they fit into neat compartments, and as though the conception-gestation-rearing relationship is entirely negotiable ... concerns for embodiment and thus for reproduction as a whole process mitigate against treating parental obligations and entitlements in isolation from the experiences of conception, pregnancy and birth.²⁶⁷

Best Interests of the Child

The notion of the best interests of the child is formally recognized in the law and has been discussed at some length in this paper. We have

noted that there are inherent weaknesses in the doctrine in terms of its fairness and the difficulty of assessing adequately exactly what it means.

It is critical, when making choices as to which parties involved in AHR are to be given the legal attribution of mother or father, that legislators and policy makers do not simply assess the situation on a determination of the most logical party from the contestants' point of view. It is critical to commence the analysis from the perspective of the child. In addition, if legal parenthood is to play a significant role in the determination of custody in a custody dispute, one must decide issues of parenthood alongside issues of custody.

It is of significant interest to the authors that while the doctrine of the best interests of the child is hotly debated in the context of family law disputes, it appears to have little relevance to the issue of how the NRTs affect the family. It is our contention that failure to recognize the importance of the child's best interests may result in inappropriate legislation. When making policy decisions in an area that has a profound effect on children, it is critical that their perspective on the relevant issues be uppermost in policy makers' minds.

One question that may initially appear somewhat peripheral to the impact of the NRTs on family law is whether alternative families — two same-sex parents or single individuals — should be permitted access to AHR. However, it is an important issue because it raises questions about one of the fundamental principles of family law: a child can have only one legal mother and one legal father. As we have noted previously, this principle is further substantiated by a tendency of the courts to ensure, where possible, that each child does have one mother and one father.

We have noted that the present consent legislation in three Canadian provinces requires the consent of the spouse of a woman seeking AID before he will be held responsible for the child as the child's legal parent. We also noted that there has been some question as to what the purpose of the consent legislation is: whether it is to act as a condition precedent to receiving access to AID (meaning that access will be restricted if such consent is not forthcoming), or whether it is simply to protect both the spouse (from unintended parental liability) and the child (from losing a potential parent who had consented to the assumption of responsibility). However, this has not dealt with the problem of whether singles or alternative families should be entitled to access to AHR.

Does our society have an over-riding interest in protecting a child's "right" to two parents of the opposite sex? Is the child's interest in this regard so important that we should restrict access to only those couples living in stable heterosexual relationships? Should the intention of a donor not to assume parental responsibility for the child born of his or her donation be thwarted: for example, in the case where a male social parent is not in place to assume the responsibility the sperm donor has given up — such as when a single woman or a lesbian couple uses donor sperm?

How one responds to these questions is very important for how we structure family law. Our existing model of the family is, as we have shown, not very flexible. While social acceptance of alternative family forms is certainly growing, the law has been slow to give any recognition to them at all.

There is a growing fear that the traditional nuclear family is suffering, and that this will be to the detriment of society. Although one of the functions of the law is to reflect social values, it is critical that legislation in fact protects those requiring protection. In the case of family law, the child is often the one requiring protection.

The rationale for protecting a child's right to two parents is arguably the protection of three interests:

1. the right of a child to two parents within a social context, to avoid the stigma of the one-parent family, to give the child a social family within which to grow up and a social and cultural heritage;
2. the right of a child to have financial support from two parents; and
3. the right of a child to have two lines of lineage — the right to a biological heritage, including information about genetic history, physical attributes, and so on.

In the juncture where family law meets AHR, the two-parent model for the family may not be appropriate. The interests of the child may be met adequately in alternative family forms. Once we move away from a society in which the process of reproduction is limited to the results of sexual intercourse, our traditional family model loses some relevance. Strictly limiting parenthood to two individuals of opposite sex for each child born will sometimes constitute a legal fiction. If we are willing to maintain this fiction, we must understand the rationale behind it.

If decisions regarding children are to be made in their best interests, perhaps decisions about an ideal structure of the family are misplaced. If the reality is that children live in different types of family situations — as noted by the Vanier Institute in its submission to the Royal Commission — perhaps it is inappropriate to have a set definition of what a legal family is. To limit the legal family, as we do, means that those who live in one of the many alternative family structures cannot rely on the courts for assistance in settling disputes. Where children are involved (e.g., where a lesbian couple with children wishes to separate), it cannot be in the child's best interests for the court to maintain the one-mother rule so that, even with creative litigating, the non-legal mother is at a substantial disadvantage. Surely it would be more appropriate to encompass that second "mother" in the legal definition of mother and put her on an equal footing with her former partner in settling custody and access issues. In this way, the pre-eminence of the legal parents that is enshrined in the parental rights

doctrine can be maintained, while the real interests of the child are protected.

When we examine the case law and the commentary on custody, access, and support disputes, it is clear that should we retain a one-mother/one-father model for parenthood, and should we leave the parental rights doctrine intact, we will leave the courts with an extremely difficult task. If we presume that the one-mother/one-father model is the most appropriate model for parenthood in our social context (or suggest that a change to that model is too revolutionary), we can assist the courts by legislating which of the competing individuals should be the legal parents. However, if we stop there, the children born into these situations may commence their lives as the subject of a protracted legal dispute over who should have custody of them. The competing parties will often have little in common socially, and the failure to have a readily identifiable parent from the start will arguably create an extremely detrimental situation for the children.

It is critical that those making policy or passing legislation dealing with issues that arise as a result of the NRTs not do so without an understanding of what impact their recommendations or legislation will have on other issues. For example, the complications of determining parental status and the rights and obligations of individuals for children are not only relevant in the context of AHR, but they will have a rebound effect on all of our different family structures. The impact of deciding on issues in relation to AHR will be felt throughout the legal system as it relates to the family and family obligations.

Rendering contracts for surrogacy null and unenforceable, and even setting penal sanctions for intermediaries, does not necessarily eradicate the possibility that such arrangements will be undertaken. The same applies to limiting access to AID to women in stable heterosexual couples, both members of which consent to the procedure. History has demonstrated that the ease with which AID can be undertaken means that should we limit the "legitimate" procedure to such couples, women who wish to single parent or to co-parent with a female partner will seek their own donors and conduct the procedure themselves.²⁶⁸ Children resulting from such arrangements will in fact exist. Legislators cannot simply turn a "blind eye" to the potential problems. The attribution of parenthood must have set guidelines, or the judiciary will have to tackle the situation on the basis of pre-existing law.

Regulatory Choices

Introduction

Different approaches may be taken to manage the effects of the NRTs on family law. In this section we examine the following models: (1) status

quo, (2) private ordering, (3) moderate legislative intervention, (4) full regulation, and (5) criminalization.

Before outlining the characteristics of each approach, we should review some of the issues raised in this paper that may require regulation.

1. AID

- Should the donor bear any liability for a child born of his sperm?
- Should the donor be entitled to extinguish all of his parental rights and responsibilities at the time of the donation?
- Should a woman seeking AID be required to provide a social father for the child, and, before access is given, must she have the consent of her male social partner?
- Should single women be given access to AID?
- Should lesbian individuals or couples be given access to AID?
- Should consent of a second person (father or second mother) be limited to consent to the assumption of parental responsibility?
- Should the form in which the consent is given be regulated so as to eradicate many of the evidentiary problems of proving consent?
- Should donor records be maintained? If so, what type of information should be included?

2. Donated Ova

- Should ovum donation be regulated along the same lines as AID?

3. Genetic/Gestational Motherhood

- Should contracts for genetic/gestational "services" be permitted?
- If they are not permitted, should they merely be unenforceable or should there be punitive sanctions applied?
- Which of the potentially competing individuals should be presumed to be the child's legal parents? Or should there be such presumptions?
- The genetic/gestational mother — should her spouse be presumed to be the child's legal father? If we adopt consent legislation along the lines of that in Quebec, Newfoundland, and the Yukon, an exception must be made to the presumption of paternity in the gestational mother's husband if we decide to recognize these types of contracts.
- The sperm contributor/commissioning male — should his spouse have a presumed right to be the child's mother on the basis of her intention to parent, combined with the consent of the genetic/gestational mother to the termination of her parental rights? Should the intended mother have to give written consent? Should he be the child's presumed father?

- If we accept that the genetic/gestational mother and the genetic father (commissioning male) are the legal parents of the child, do we accept the fact that if there is a dispute over custody, the existing law on custody will prevail? Should there be some recognition of the commissioning partner not related to the child, as a legal parent, alongside the two genetic parents?
- Should we recognize a right of a child to have more than two legal parents?
- Even where these contracts are not permitted, we must recognize that there is the potential for clandestine arrangements that will result in the birth of a child and a potential custody battle: how should this be dealt with in the law?
- Is there a way to discourage such arrangements so that these disputes do not end up before the courts?
- Should records be maintained on genetic/gestational motherhood contracts?

4. Gestational Motherhood

- When a woman gestates an embryo for another individual or couple, should she have a right to the legal attribution of motherhood? Or should that right reside exclusively with the genetic progenitor, or should we decide on the basis of intention?

Status Quo

One “solution” to the problems of integrating the children born as a result of the NRTs into the legal family is to permit the system to adapt itself (i.e., to maintain the status quo):

[T]he fact that legislation does not speak directly to a certain matter is not, in itself, a damning criticism necessitating immediate remedial action. Silence may well reflect continuing, deep-seated controversy, so that there may be a justifiable wish to permit the law to develop without legislative fetters. Even inadvertent solutions may be equitable responses — a manifestation of the capacity of the legal regime, created to deal with one set of circumstances, to grow and flourish in a new milieu.²⁶⁹

One of the most significant drawbacks of this approach is that children born as a result of the technologies will be the victims of the search for consistent application of the new principles to be set by the judiciary. Many issues that arise in the context of AHR are so fundamentally different from the factual basis on which the relevant legislation was drafted that failure to provide legislative direction will mean that the judiciary will be responsible for creating new law. One of the most significant problems with this is that there will be little consistency in the law for a substantial period of time, until the highest courts have ruled on a par-

ticular issue. It also means that the problems inherent in the present resolution of custody disputes will become more complicated. The courts will need to develop creative solutions to these problems to protect the best interests of the children who are objects of the litigation. In the meantime, it will be difficult for all individuals participating in the new technologies to have a clear idea of precisely what they are risking.

Private Ordering

The private ordering model would allow individuals to enter into whatever contractual arrangements suited them. The courts would then apply traditional contract law to enforce the agreement or to vitiate it on such grounds as it would a commercial contract (e.g., fraud, coercion, duress). This model is espoused by many of those who support the doctrine of intent as the basis for parental status: "The private ordering approach envisages a basically facultative, non-judgmental legal regime, where, either actively or passively, the law permits people to arrange their affairs as they see fit."²⁷⁰

Under this scheme, the parties to an agreement would be permitted to define who is to be a legal parent and who should have custody of the child. Therefore, a commissioning couple in a contract with a genetic/gestational mother could contract for the exclusive right to parental status.

In its purest form, the private ordering model would permit the enforceability of all valid contracts. For example, the contract for genetic/gestational motherhood would be specifically enforceable (i.e., by termination of the genetic/gestational mother's parental rights).

Moderate Legislative Intervention

If legislators decide that retaining the status quo is insufficient or that the private ordering model leaves too much room for inequity or is inappropriate for protecting the interests of the family, they can take a moderate approach to legislative intervention.

The objective of a uniform approach regulating new reproductive practices is difficult to meet, given the diversity of interests and social values to be protected. Complete consensus on a global approach to the regulation of AHR would be extremely difficult to obtain. Moderate legislative intervention would enable legislatures to protect those elements deemed to be of critical social interest.

Three provinces have adopted consent legislation to regulate assisted forms of human reproduction. This is an example of moderate legislative intervention. The advantage of this approach is that issues can be dealt with by the legislatures as and when they become problematic. It is premised on the notion that the state has an interest to protect; legislative intervention will be undertaken to preserve that interest when appropriate. The changes to the Civil Code of Quebec have gone further than the earlier law and maintain a moderate level of intervention.

Full Regulation

Under this model, the legislature would have to recognize that the new collaborative reproduction arrangements are acceptable in principle, but only where there is total control over how they are done.

The particular focus here is the genetic/gestational motherhood contract. Full regulation would mean the regulation of all the terms of the contract. The government could create agencies or license brokers to act as intermediaries to the contract. The government would have the capacity and the duty to oversee all of the aspects of the contract.

Punitive

Where it is decided that certain of the activities related to collaborative reproduction are totally unacceptable, it is possible to sanction against such involvement. Contracts could be strictly unenforceable or could be subject to criminal or civil sanction.²⁷¹

In Canada, this would mean that a given act could be sanctioned against by bringing it within the ambit of the Criminal Code, and thus within the control of the federal government. The provincial governments have limited authority and can sanction only against activities under provincial jurisdiction.

Should Canadian law makers decide that contracts for genetic/gestational motherhood should simply not be enforced, they must carefully consider the effects that such legislation will have. One of the objectives of making a contract unenforceable is to discourage reliance on such a contract. Where there are no punitive sanctions for entering into a contract for genetic/gestational motherhood, it is likely that the courts will be faced with custody disputes.

Conclusion

Many problems arise in the context of AHR and family law. The area is complex and fraught with emotional and moral complications. It is our hope that this paper has made clear how difficult this area is and how important it is to concentrate on the implications of AHR for the families that use it.

In our view, too much of the debate on AHR concentrates on the scientific and pre-birth aspects of this technological revolution. Ultimately, the purpose of the technologies is the creation of human life. We cannot accept that the mere opportunity to be born is enough to satisfy responsibility to the children that result from AHR. Where we have control over the creation of human life, we must take that life as the starting point for regulation. We must work backwards from the child to the technology to ensure that we serve the best interests of the child.

Notes

1. M.M. Shultz, "Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality," *Wisconsin Law Review* 2 (1990), 301.
2. The term "collaborative reproduction" is a term used to refer to reproduction where a party, or parties, relies on donated gametes or gestation for the creation of a child. See J.A. Robertson, "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction," *Southern California Law Review* 59 (1986), 1001.
3. Pursuant to Section 91(26) of the Constitution Act, 1982 (being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11), the federal Parliament has the power to make laws in relation to "marriage and divorce," which includes the right to marry, to whom and at what age one may marry, and divorce and measures for corollary relief within the context of divorce; the general jurisdiction over family law, which resides with the provincial legislatures, stems from section 92(13), which gives them power over property and civil rights in the province. Property and civil rights include, for example, matrimonial property, successions, adoption, custody and access, support, legitimacy, filiation, etc. For further information on constitutional issues, see P.W. Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985); basic text on family law: B. Hovius, *Family Law: Cases, Notes and Materials*, 2d ed. (Toronto: Carswell, 1987).
4. H.C. Black, *Black's Law Dictionary*, 5th ed. (St. Paul: West Publishing, 1979), 543.
5. R. Macklin, "Artificial Means of Reproduction and Our Understanding of the Family," *Hastings Center Report* 21 (January-February 1991): 5-11.
6. Vanier Institute of the Family, "A Family Perspective on the New Reproductive Technologies," submission to the Royal Commission on New Reproductive Technologies, Ottawa, 1990, 4.
7. Macklin, *supra*, note 5, 6-7.
8. Susan Moller Okin argues that this public/private distinction works to insulate the private realm of the family from social concepts of justice and equality, rendering the family the last bastion of male domination that has not been investigated or addressed. S.M. Okin, *Justice, Gender, and the Family* (New York: Basic Books, 1989). For a critique of Okin, see W. Kymlicka, "Rethinking the Family," *Philosophy and Public Affairs* 20 (1991): 77-97.
9. See *infra*.
10. Shultz, *supra*, note 1, 299-300.
11. See *infra*, section entitled "Presumption of Paternity."
12. "Marriage and Conjugal Life in Canada," Statistics Canada, April 1992, as cited in A. Mitchell, "Marriages in Decline, Data Show," *Globe and Mail* (24 April 1992), A20.
13. *Ibid.*
14. Within this context, there are a number of provisions that exist in the legislation that may have a puzzling effect on those children whose birth was contingent on AHR and on their "parents." For example, the definition section of the Alberta

Child Welfare Act, S.A. 1984, c. C-8.1, s. 1(b), as amended, defines "biological mother" as "the woman who gave birth to the child"; it is arguable whether this definition should apply to the situation where a woman gestates a fetus that is not genetically linked to her. The answer to that question is of significant social policy impact.

15. B. Freedman et al., "Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices," *Canadian Family Law Quarterly* 3 (1988): 35-54.
16. L.L. Long, "Artificially Assisted Conception," *Health Law in Canada* 5 (1985), 96; see also: P. Coleman, "Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions," *Tennessee Law Review* 50 (1982), 75; A.E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies," *Yale Law Journal* 96 (1986), 190.
17. M. Minow, "Redefining Families: Who's In and Who's Out?" *University of Colorado Law Review* 62 (1991), 271.
18. Shultz, *supra*, note 1, 304-307. Until recently, pregnancy and giving birth to children were largely outside the realm of individual control; however, contraceptives and abortion have to some extent permitted women some control over procreation and therefore the decision to become a parent. "While contraception and abortion allow sex without procreation, modern reproductive technologies allow procreation without sex" (p. 309).
19. *Ibid.*, 315.
20. M. Christiaens, "Artificial Insemination by Donor and the View of Man," *European Journal of Obstetrics & Gynecology and Reproductive Biology* 28 (1988) 350.
21. Robertson, *supra*, note 2, 965, fn. 78, citing R.J. Lifton, *The Life of the Self: Toward a New Psychology* (New York: Simon and Shuster, 1976), 29-33.
22. Vanier Institute of the Family, *supra*, note 6, 30.
23. J.E. Vevers, "The Social Meaning of Parenthood," *Psychiatry* 36 (1973), 305.
24. M.A. Ryan, "The Argument for Unlimited Procreative Liberty: A Feminist Critique," *Hastings Center Report* 20 (July-August 1990), 10.
25. J.L. Hill, "What Does It Mean to Be a 'Parent'? The Claims of Biology as the Basis for Parental Rights," *New York University Law Review* 66 (1991), 354.
26. *Ibid.*, 355. Furthermore, as Ryan notes, *supra*, note 24, 10, when individuals assume parental obligations for children with whom they are not biologically related, we modify the term "parent" with the adjective "adoptive" or "foster," thereby preserving a sense of biological identity.
27. We use the phrase "procreative process" to include not only the biological progenitors and the gestator but also "intended social parents" who have no biological connection to a child. See Hill, *supra*, note 25, and Stumpf, *supra*, note 16, 167, for further discussion of this notion of the procreative process.
28. Hill, *supra*, note 25; Long, *supra*, note 16, 89.
29. BRITISH COLUMBIA: Law and Equity Act, R.S.B.C. 1979, c. 224, s. 56(1); MANITOBA: The Family Maintenance Act, R.S.M. 1987, c. F-20, s. 17; NEW BRUNSWICK: Family Services Act, S.N.B. 1980, c. F-2.2, s. 96(4); NEWFOUND-

- LAND: The Children's Law Act, R.S. Nfld. 1990, c. C-13, s. 3(4); NORTHWEST TERRITORIES: Child Welfare Act, R.S.N.W.T. 1988, c. C-6, s. 77(2); ONTARIO: Children's Law Reform Act, R.S.O. 1990, c. C.12, s. 1; PRINCE EDWARD ISLAND: Child Status Act, R.S.P.E.I. 1988, c. C-6, s. 1(4); QUEBEC: Civil Code of Quebec (C.C.Q.), S.Q. 1991, c. 64, art. 594; SASKATCHEWAN: The Children's Law Act, S.S. 1990, c. C-8.1, s. 40; YUKON: Children's Act, R.S.Y. 1986, c. 22, s. 5(4).
30. QUEBEC: C.C.Q., art. 572.
31. QUEBEC: Civil Code of Lower Canada (C.C.L.C.), art. 54.
32. QUEBEC: C.C.Q., art. 587.
33. ALBERTA: Vital Statistics Act, R.S.A. 1980, c. V-4, s. 3; BRITISH COLUMBIA: Vital Statistics Amendment Act 1987, S.B.C. 1987, c. 32, s. 2; MANITOBA: The Vital Statistics Act, R.S.M. 1987, c. V60, s. 3; NEW BRUNSWICK: Vital Statistics Act, S.N.B. 1979, c. V-3, s. 7; NEWFOUNDLAND: Vital Statistics Act, R.S.Nfld. 1990, c. V-6, s. 10; NOVA SCOTIA: Vital Statistics Act, R.S.N.S. 1989, c. 494, s. 4; NORTHWEST TERRITORIES: Vital Statistics Act, R.S.N.W.T. 1988, c. V-3, s. 2; ONTARIO: Vital Statistics Act, R.S.O. 1990, c. V.4, s. 9; PRINCE EDWARD ISLAND: Vital Statistics Act, R.S.P.E.I. 1988, c. V-4, s. 5; QUEBEC: C.C.L.C., arts. 54-56; SASKATCHEWAN: The Vital Statistics Act, R.S.S. 1978, c. V-7, s. 4; YUKON: Vital Statistics Act, R.S.Y. 1986, c. 175, s. 4.
34. Ontario Law Reform Commission (OLRC), *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985), vol. 1, 66-67; ALBERTA: Vital Statistics Act, s. 3(6); MANITOBA: The Vital Statistics Act, s. 3(5), (7); NEW BRUNSWICK: Vital Statistics Act, s. 8; NOVA SCOTIA: Vital Statistics Act, s. 4(5).
35. The Civil Code of Lower Canada requires the signature of the parents only if they are present (art. 55). If the parents are not married and the father is not present at the registration of the birth, the civil registrar must obtain his authorization before entering his name. It is not certain whether similar authorization must be requested when the parents are married. See *Droits de la famille* 526, [1988] RJQ 1966 (CA), commentary by S. Barrière, "Les actes de naissances: qui peut déclarer et quoi," *Revue du Barreau* 49 (1989): 165; see also P.B. Migneault, *Le droit civil canadien* (Montreal: Whitford and Théoret, 1895), e. 210.
36. OLRC, *supra*, note 34, 67.
37. Throughout this text, where reference is made to those sections of the Civil Code not yet in force, that fact will be noted. For ease of identification, reference will be to the relevant article of Bill 125, the former referent for the Civil Code of Quebec, c. 64 S.Q. 1991, c. 64.
38. QUEBEC: Bill 125, art. 111.
39. QUEBEC: Bill 125, art. 112.
40. QUEBEC: Bill 125, art. 113.
41. QUEBEC: Bill 125, art. 114.
42. G.J. Annas, "Redefining Parenthood and Protecting Embryos: Why We Need New Laws," *Hastings Center Report* 14 (October 1984), 51.
43. M.D. Castelli, *Précis de droit de la famille* (Quebec: Presses de l'Université Laval, 1987), 119; S. Le Bris, "Procréation assistée et parentalité en droit français et

québécois," L.L.M. Université de Montréal, 1988, 36; J.K. Mason and R.A. McCall Smith, *Law and Medical Ethics* (London: Butterworths, 1983), 46.

44. ALBERTA: Vital Statistics Act, s. 1(a); BRITISH COLUMBIA: Vital Statistics Act, R.S.B.C. 1979, c. 425, s. 1; MANITOBA: The Vital Statistics Act, s. 1; NEW BRUNSWICK: Vital Statistics Act, s. 1; NOVA SCOTIA: Vital Statistics Act, s. 2; NORTHWEST TERRITORIES: Vital Statistics Act, s. 1; ONTARIO: Vital Statistics Act, s. 1; PRINCE EDWARD ISLAND: Vital Statistics Act, s. 1; SASKATCHEWAN: The Vital Statistics Act, s. 2; YUKON: Vital Statistics Act, s. 1.

45. ALBERTA: Domestic Relations Act, R.S.A. 1980, c. D-37, s. 64 — standing is limited to "a person claiming to be the father, mother or child of another person"; MANITOBA: The Family Maintenance Act, s. 19; NEWFOUNDLAND: Children's Law Act, s. 6; NEW BRUNSWICK: Family Services Act, s. 100; NORTHWEST TERRITORIES: Child Welfare Act, s. 79; ONTARIO: Children's Law Reform Act, s. 4; PRINCE EDWARD ISLAND: Child Status Act, s. 5; QUEBEC: C.C.Q., art. 588; SASKATCHEWAN: The Children's Law Act, s. 43; YUKON: Children's Act, s. 8.

46. QUEBEC: C.C.Q., art. 589; Bill 125, art. 530.

47. Note again that the presumption of paternity plays a role secondary to the act of birth and possession of status in Quebec law.

48. ALBERTA: Parentage and Maintenance Act, S.A. 1990, c. P-0.7, s. 12(1), notes that in section 12 (d) there is a stipulation that the cohabiting couple live together for at least one year prior to the birth; there is no reference to what happens to the presumption on the separation of the cohabiting couple (i.e., does the presumption terminate on separation rather than applying the 300-day rule); BRITISH COLUMBIA: Family Relations Act, R.S.B.C. 1979, c. 121, s. 61.2; MANITOBA: The Family Maintenance Act, s. 23; NEWFOUNDLAND: Children's Law Act, s. 10(1); NEW BRUNSWICK: Family Services Act, s. 103; NORTHWEST TERRITORIES: Child Welfare Act, s. 82; ONTARIO: Children's Law Reform Act, s. 8; PRINCE EDWARD ISLAND: Child Status Act, s. 9; SASKATCHEWAN: The Children's Law Act, s. 45, is essentially the same but for the absence of a "300-day rule" for the couple who had been living together. Section 4(6) of the Saskatchewan Vital Statistics Act also permits a voluntary acknowledgment of paternity to over-ride the presumption where the mother of the child includes an affirmation "that at the time of conception of the child she was living separate and apart from her husband"; YUKON: Children's Act, s. 12.

49. QUEBEC: C.C.Q., art. 574. Bill 125 retains the basics of the presumption in art. 525.

50. QUEBEC: C.C.Q., arts. 574 and 575.

51. QUEBEC: C.C.Q., arts. 577 *et seq.*; Bill 125, arts. 526-529.

52. ALBERTA: Parentage and Maintenance Act, s. 12(2); BRITISH COLUMBIA: Family Relations Act, s. 61.2(3); NEWFOUNDLAND: Children's Law Act, s. 10(2); NEW BRUNSWICK: Family Services Act, s. 103(3); NORTHWEST TERRITORIES: Child Welfare Act, s. 82(3), unless there is a declaration of paternity; ONTARIO: Children's Law Reform Act, s. 8(3); PRINCE EDWARD ISLAND: Child Status Act, 9(3).

53. MANITOBA: The Family Maintenance Act, s. 20(5).

54. ALBERTA: Parentage and Maintenance Act, s. 15(2).

55. NOVA SCOTIA: Family Maintenance Act, s. 2: “‘possible father’ includes any one or more persons who have had sexual intercourse with a single woman who is the mother of a child and by whom it is possible that she was pregnant.”
56. BRITISH COLUMBIA: Family Relations Act, s. 61.2(1)(f); MANITOBA: The Family Maintenance Act, s. 23(d), 24(2) — such an acknowledgment may be filed with the office of the director; NEW BRUNSWICK: Family Services Act, s. 105; NEWFOUNDLAND: Children’s Law Act, s. 11(2); NORTHWEST TERRITORIES: Child Welfare Act, s. 83; ONTARIO: Children’s Law Reform Act, s. 12 — this section allows a woman to file a statutory declaration affirming the fact that she is the child’s mother as well; PRINCE EDWARD ISLAND: Child Status Act, s. 12; QUEBEC: C.C.Q., arts. 577, 578; Bill 125, arts. 526-529; SASKATCHEWAN: The Children’s Law Act, s. 46.
57. QUEBEC: C.C.Q., art. 579; Bill 125, art. 528.
58. NEW BRUNSWICK: Family Services Act, s. 104; NORTHWEST TERRITORIES: Child Welfare Act, s. 85.
59. ALBERTA: Domestic Relations Act, s. 64 — standing is limited to “a person claiming to be the father, mother or child of another person”; MANITOBA: The Family Maintenance Act, s. 20; NEWFOUNDLAND: Children’s Law Act, ss. 6 and 7; NEW BRUNSWICK: Family Services Act, s. 100; NORTHWEST TERRITORIES: Child Welfare Act, s. 79; ONTARIO: Children’s Law Reform Act, s. 4; PRINCE EDWARD ISLAND: Child Status Act, s. 5; SASKATCHEWAN: The Children’s Law Act, s. 43; YUKON: Children’s Act, s. 9.
60. QUEBEC: C.C.Q., art. 589.
61. MANITOBA: The Family Maintenance Act, s. 20; NEWFOUNDLAND: Children’s Law Act, s. 7(7); SASKATCHEWAN: The Children’s Law Act, s. 43(7), states: “An application pursuant to this section may be made whether or not the person and the child whose relationship is sought to be established are alive”; YUKON: Children’s Act, s. 9(5), stipulates that “where only the father or the child is living and the court finds that a presumption of paternity exists under section 12, the court may make a declaratory order that a person is in law the father of the child.”
62. SASKATCHEWAN: The Children of Unmarried Parents Act, R.S.S. 1978, c. C-8, s. 3.
63. ALBERTA: Vital Statistics Act, s. 34; BRITISH COLUMBIA: Vital Statistics Act, s. 32; MANITOBA: The Vital Statistics Act, s. 34; NEW BRUNSWICK: Vital Statistics Act, s. 42; NOVA SCOTIA: Vital Statistics Act, s. 39(1); NORTHWEST TERRITORIES: Vital Statistics Act, s. 38; ONTARIO: Vital Statistics Act, s. 46; PRINCE EDWARD ISLAND: Vital Statistics Act, s. 36; QUEBEC: C.C.Q., art. 572; SASKATCHEWAN: The Vital Statistics Act, s. 42.
64. QUEBEC: C.C.Q., arts. 581, 582; Bill 125, art. 532, stipulates that the child, the child’s father, or the child’s mother may challenge the child’s filiation in their regard — as long as there is no consistent title and possession of status.
65. MANITOBA: The Family Maintenance Act, s. 20; NEWFOUNDLAND: Children’s Law Act, s. 7.
66. ALBERTA: Vital Statistics Act, s. 34(3)(4).
67. D.E. Salisbury, “The Use of Blood Test Evidence in Paternity Suits: A Scientific and Legal Analysis,” *Faculty Law Review* 30 (1972): 47-74. The Human Leukocyte Antigen test is considered to be 98 to 99 percent accurate.

68. ALBERTA: Parentage and Maintenance Act, s. 13; MANITOBA: The Family Maintenance Act, s. 21; NEWFOUNDLAND: Children's Law Act, s. 8; NEW BRUNSWICK: Family Services Act, s. 110(4); ONTARIO: Children's Law Reform Act, s. 10(3); PRINCE EDWARD ISLAND: Child Status Act, s. 10(3); SASKATCHEWAN: The Children's Law Act, s. 48(3).

69. NEWFOUNDLAND: Children's Law Act, s. 12, includes AI where such occurs *in vitro*.

70. Le Bris, *supra*, note 43, 65.

71. Presuming that he did not treat the child as his own, nor was he treated as the child's father, as that "possession of status" combined with the birth certificate would cause the presumption of paternity, which stems from his marriage to the child's mother, to become irrebuttable unless it could be established that he had not known about the reliance on donor insemination.

72. YUKON: Children's Act, s. 13.

73. ALBERTA: Child Welfare Act, 56(1)(a); BRITISH COLUMBIA: Adoption Act, R.S.B.C. 1979, c. 4, s. 8(8); references herein include changes to the Adoption Act by S.B.C. 1990, c. 30; where a section is not yet in force, the existing law and the new law are both referred to; MANITOBA: The Child and Family Services Act, R.S.M. 1987, c. C-80, s. 58(7); NEW BRUNSWICK: Family Services Act, s. 78; NEWFOUNDLAND: Adoption of Children Act, R.S.Nfld. 1990, c. A-3, ss. 10, 11; NORTHWEST TERRITORIES: Child Welfare Act, s. 93(4); NOVA SCOTIA: Children and Family Services Act, S.N.S. 1990, c. 5, s. 70; ONTARIO: Child and Family Services Act, R.S.O. 1990, c. C.11, s. 137; PRINCE EDWARD ISLAND: Adoption Act, R.S.P.E.I. 1988, c. A-4, s. 6; QUEBEC: C.C.Q., art. 603; SASKATCHEWAN: The Adoption Act, S.S. 1989-90, c. A-5.1, s. 5; YUKON: Children's Act, s. 82.

74. ALBERTA: Child Welfare Act, s. 58; BRITISH COLUMBIA: Adoption Act, s. 3(1); MANITOBA: The Child and Family Services Act, s. 66(1); NEWFOUNDLAND: Adoption of Children Act, s. 3; NEW BRUNSWICK: Family Services Act, s. 66; NORTHWEST TERRITORIES: Child Welfare Act, s. 89; NOVA SCOTIA: Children's Services Act, R.S.N.S. 1989, c. 68, s. 13; ONTARIO: Child and Family Services Act, s. 146(4); PRINCE EDWARD ISLAND: Adoption Act, s. 3; QUEBEC: C.C.Q., art. 598; SASKATCHEWAN: The Adoption Act, s. 17(2).

75. BRITISH COLUMBIA: Adoption Act, s. 3(1); MANITOBA: The Child and Family Services Act, s. 66(1); NEWFOUNDLAND: Adoption of Children Act, s. 3; NEW BRUNSWICK: Family Services Act, s. 66; NORTHWEST TERRITORIES: Child Welfare Act, s. 89; ONTARIO: Child and Family Services Act, s. 146(4); PRINCE EDWARD ISLAND: Adoption Act, s. 3.

76. MANITOBA: The Child and Family Services Act, s. 66(1); ONTARIO: Child and Family Services Act, s. 146(4)(6), read with para. 136(1) of the same act; QUEBEC: C.C.Q., art. 598; SASKATCHEWAN: The Adoption Act, s. 17(2)(c), provides that an application for adoption may be made by "any other person or persons that the court may allow, having regard to the best interests of the child."

77. The provision that permits a single adult to adopt means that a couple living in a de facto relationship could presumably adopt a child but the child would have only one legal parent — the parent who applied to adopt the child.

78. ALBERTA: Child Welfare Act, s. 65; BRITISH COLUMBIA: Adoption Act, s. 11; MANITOBA: The Family Maintenance Act, s. 17; MANITOBA: The Child and Family Services Act, s. 61; NEWFOUNDLAND: Adoption of Children Act, s. 20; NEW BRUNSWICK: Family Services Act, s. 85; NORTHWEST TERRITORIES: Child Welfare Act, s. 100; NOVA SCOTIA: Children's Services Act, s. 23; ONTARIO: Child and Family Services Act, s. 158(2); PRINCE EDWARD ISLAND: Adoption Act, s. 18; QUEBEC: C.C.Q., art. 627; SASKATCHEWAN: The Adoption Act, s. 18; YUKON: Children's Act, s. 98.
79. ALBERTA: Child Welfare Act, s. 70; MANITOBA: The Child and Family Services Act, ss. 55, 58; NEW BRUNSWICK: Family Services Act, s. 67; ONTARIO: Child and Family Services Act, s. 141; PRINCE EDWARD ISLAND: Adoption Act, s. 5; SASKATCHEWAN: The Adoption Act, s. 11.
80. ONTARIO: Child and Family Services Act, s. 141.
81. ALBERTA: Child Welfare Act, s. 59; BRITISH COLUMBIA: Adoption Act, s. 3.1(1): "No person other than an adult birth parent who has guardianship of the person of a child shall make a direct placement or act as an intermediary to facilitate the direct placement of that child"; this provision has not yet been proclaimed in force; MANITOBA: The Child and Family Services Act, s. 69; NEW BRUNSWICK: Family Services Act, s. 69; SASKATCHEWAN: The Adoption Act, s. 14.
82. ALBERTA: Child Welfare Act, s. 61; BRITISH COLUMBIA: Adoption Act, s. 3.1(3)(4), not yet proclaimed in force; MANITOBA: The Child and Family Services Act, s. 69; NEW BRUNSWICK: Family Services Act, s. 73; NOVA SCOTIA: Children's Services Act, s. 14; PRINCE EDWARD ISLAND: Adoption Act, s. 4.
83. NEWFOUNDLAND: Adoption of Children Act, s. 3(3) — except where the child is placed with his or her mother, father, sister, brother, aunt, or uncle of a mother or father of the child; QUEBEC: C.C.Q., art. 607.
84. ALBERTA: Child Welfare Act, s. 56; BRITISH COLUMBIA: Adoption Act, s. 8, consent must be given by the child's mother, the man who has acknowledged paternity of the child by signing the birth registration, a man who is the child's guardian, or a man who has acknowledged paternity and has access or custody rights to the child. MANITOBA: The Child and Family Services Act, s. 58; NEW BRUNSWICK: Family Services Act, s. 76, the child's parent or guardian must consent: "Parent" in that legislation includes the natural father of the child who has signed the birth registration or has filed with the mother a statutory declaration of paternity or has been named the father in a declaratory order or is a person with whom the child ordinarily resides who has demonstrated a settled intention to treat the child as a child of his or her family, *ibid.*, s. 1; NORTHWEST TERRITORIES: Child Welfare Act, s. 93.
85. NEWFOUNDLAND: Adoption of Children Act, s. 10; QUEBEC: C.C.Q., art. 603.
86. SASKATCHEWAN: The Adoption Act, s. 5.
87. PRINCE EDWARD ISLAND: Adoption Act, s. 6.
88. MANITOBA: The Child and Family Services Act, s. 58(5).
89. QUEBEC: C.C.Q., art. 607.
90. BRITISH COLUMBIA: Adoption Act, s. 8(5), written consent of a mother good only if the child was at least 10 days old at the time of execution; MANITOBA: The Child and Family Services Act, s. 58(3), 10 clear days after birth; NEWFOUNDLAND:

Adoption of Children Act, s. 12(5), consent not valid unless the child was at least 7 days old at the time the consent was given; NEW BRUNSWICK: The Family Services Act, s. 76(5), the consent of the parent to the adoption of his or her child may be given at any time after the birth of the child, but if given during the first 7 days of the child's life it has no force and effect until the expiry of the seventh day after the birth; NORTHWEST TERRITORIES: Child Welfare Act, s. 94, consent of the mother must be given after the expiration of 4 days from the birth of the child; NOVA SCOTIA: Children and Family Services Act, s. 68(2), "The term of an adoption agreement ... shall not be effective until 15 days after the birth of the child"; ONTARIO: Child and Family Services Act, s. 137(3), 7 days old; PRINCE EDWARD ISLAND: Adoption Act, s. 6(6), child must be 14 days old at the time of the execution of the document; SASKATCHEWAN: The Adoption Act, s. 5(2), child must be at least 3 days old.

91. ALBERTA: Child Welfare Act, s. 57(1), consent may be revoked in writing up to 10 days after the consent is given; ONTARIO: Child and Family Services Act, ss. 137(8) and 139, 21 days, or later if it is in the child's best interests, s. 139; QUEBEC: C.C.Q., art. 609, the consenting person has a right to withdraw his or her consent within 30 days from the date when the consent for adoption was given. After the expiration of the 30 days but prior to the order of placement being granted, the consenting person may apply to the court to have the child returned, art. 610.

92. BRITISH COLUMBIA: Adoption Act, s. 8(7), if consent is withdrawn after placement, the revocation must be in the best interests of the child; NEW BRUNSWICK: Family Services Act, s. 77; NEWFOUNDLAND: Adoption of Children Act, s. 12: consent may be withdrawn within 21 days of granting it, or until time of placement. Special consideration of child's best interests will permit withdrawal of consent even after placement; SASKATCHEWAN: The Adoption Act, s. 8: revocation permitted within 14 days or until placement if in the child's best interests; YUKON: Children's Act, s. 81.

93. MANITOBA: The Child and Family Services Act, s. 58(10), withdrawal of consent with written notice.

94. ALBERTA: Child Welfare Act, ss. 59(3), 59(3) (b), requires the consent of the guardian of the child and of the child if the child is 12 years of age or over; BRITISH COLUMBIA: Adoption Act, s. 3(3), an adult husband or an adult wife may individually apply to adopt the child of either of them; MANITOBA: The Child and Family Services Act, ss. 61(5), 67(1), "a person who marries the parent of a child or a man and a woman who are not married but are cohabiting as spouses, one of whom is the parent of a child may, together ... with the consent of that parent, apply to the court on a prescribed form to adopt the child if the child is living with the applicants and is being cared for by them"; NEW BRUNSWICK: Family Services Act, s. 66(b), where adopting the child of his or her spouse, may do so without the spouse joining in the application; NORTHWEST TERRITORIES: Child Welfare Act, s. 89(c); NOVA SCOTIA: Children's Services Act, s. 13(3)(4); ONTARIO: Child and Family Services Act, s. 146(2); PRINCE EDWARD ISLAND: Adoption Act, s. 3(3), husband or wife of petitioner who is the child's parent need not join in the application; the relationship is in no way altered by the adoption; QUEBEC: C.C.Q., art. 607; SASKATCHEWAN: The Adoption Act, s. 16(3); YUKON: Children's Act, s. 79(3).

95. ALBERTA: Child Welfare Act, s. 63.1.

96. BRITISH COLUMBIA: Adoption Act, s. 7.

97. MANITOBA: The Child and Family Services Act, s. 67(4), gives the judge hearing the case the authority to request a report on the applicants; ONTARIO: Child and Family Services Act, s. 149(6).
98. NOVA SCOTIA: Children's Services Act, s. 28(5).
99. NORTHWEST TERRITORIES: Child Welfare Act, s. 104(3); PRINCE EDWARD ISLAND: Adoption Act, s. 22(2).
100. ALBERTA: Child Welfare Act, s. 66.1, 67; BRITISH COLUMBIA: Adoption Act, ss. 13.1-14; MANITOBA: The Child and Family Services Act, s. 74; NEW BRUNSWICK: Family Services Act, ss. 91-94; NEWFOUNDLAND: Adoption of Children Act, 1972, ss. 26-28; ONTARIO: Child and Family Services Act, ss. 163-169; QUEBEC: C.C.Q., art. 632; SASKATCHEWAN: The Adoption Act, s. 30; YUKON: Children's Act, s. 96.
101. ALBERTA: Child Welfare Act, s. 66.1(5): if both natural parent(s) and adopted child are registered, the Minister shall disclose identity of each to the other; BRITISH COLUMBIA: Adoption Act, s. 13.2 passive registry, s. 13.3 active registry; MANITOBA: The Child and Family Services Act, s. 74(1) passive, 74(2) active; NEW BRUNSWICK: Family Services Act, s. 92(2) passive, 92(3) active; NEWFOUNDLAND: Adoption of Children Act, 1972, s. 28(2), release of identifying information on consent; ONTARIO: Child and Family Services Act, s. 167; SASKATCHEWAN: The Adoption Act, s. 31; YUKON: Children's Act, s. 96(7); the new Civil Code of Quebec includes a provision permitting passive registry access to an adopted child from the age of 14 (art. 583).
102. BRITISH COLUMBIA: Adoption Act, s. 13.6(1)(d); NEW BRUNSWICK: Family Services Act, s. 92(2)(h); ONTARIO: Child and Family Services Act, s. 168(1); such information may be identifying or non-identifying depending on need. The new Civil Code of Quebec contains a provision (art. 584) permitting disclosure of information "where serious injury could be caused to the health of the adopted person."
103. QUEBEC: C.C.Q., art. 632.
104. Decision of Pierre Dorion J. on 16 October 1984. Cited in D. Roberge, "Normes de pratique professionnelle: renseignements dénominalisés et retrouvailles dans le contexte de l'adoption" (Montreal: Centre de Services sociaux du Montréal métropolitain, 1991), 47.
105. BRITISH COLUMBIA: Adoption Act, s. 13.4.
106. ALBERTA: Child Welfare Act, s. 67; MANITOBA: The Child and Family Services Act, s. 74(5); NEW BRUNSWICK: Family Services Act, s. 92.
107. QUEBEC: Youth Protection Act, S.Q. 1977, c. 20, amended by an Act to Provide for the Carrying Out of the Family Law Reform and to Amend the Code of Civil Procedure, S.Q. 1982, c. 17, s. 131.1.
108. Ibid., s. 131.2.
109. J. Teichman, *The Meaning of Illegitimacy* (Cambridge: Englehardt Books, 1978), 4: "It has to do with certain widespread human aims connected with the regulation of sexual activities and of population."
110. Black, *supra*, note 4..
111. There has historically been a significant amount of stigma attached to the notion of illegitimacy in our culture. Teichman notes, "Even in the quite recent past

the stigma of illegitimacy was very heavy and the disabilities very great." *Supra*, note 109, 4. The prevalence of this kind of stigma is unknown to the writers; however, as our social reality changes, such stigma will of necessity have to change. Recent comments by Vice President Quayle in the United States belie a deep-seated uneasiness with the change in our family structure.

112. D. Oliver, *Cohabitation: The Legal Implications* (Bicester: CCH Editions, 1987), 43.

113. Teichman, *supra*, note 109, 53.

114. In fact, "the laws governing the making of wills made it difficult for a man to leave an estate to an illegitimate child," *ibid.*, 54.

115. *Ibid.*, 40 *et seq.*

116. The case of *R. v. Nash*, heard in 1883, effectively overturned the common law doctrine that an illegitimate child has, in law, no parent by giving a definite weight to the natural tie existing between a child and its mother. Cited by Teichman, *ibid.*, 67.

117. *Ibid.*

118. Shultz, *supra*, note 1, 316.

119. Annas, *supra*, note 42, 51: "Previously, at birth there was never any question who the mother was since she was always both the genetic and the gestational mother (only the identity of the father was uncertain, and this uncertainty was clarified by a social decision to presume paternity in the mother's husband)."

120. H.D. Krause, "Artificial Conception: Legislative Approaches," *Family Law Quarterly* 19 (1985), 194.

121. See discussion of this issue in K.V. Lorio, "Alternative Means of Reproduction: Virgin Territory for Legislation," *Louisiana Law Review* 44 (1984), 1645 *et seq.*

122. N. Polikoff, "This Child Does Have Two Mothers: Redefining Parenthood to Meet the Needs of Children in Lesbian-Mother and Other Nontraditional Families," *Georgetown Law Journal* 78 (1990), 469.

123. Law Reform Commission of Canada, *Medically Assisted Procreation*, Working Paper 65 (Ottawa: LRC, 1992), 39.

124. Nowhere in Canada is "surrogacy" given overt sanction, and there are substantial questions as to whether a contract for gestational services would be contrary to public policy. Quebec's Bill 125 will render contracts of this nature null (art. 541). However, if we set aside that issue, several technicalities arise in these situations that cannot be easily accommodated by the present law of filiation.

125. I. Russell, "Within the Best Interests of the Child: The Factor of Parental Status in Custody Disputes Arising from Surrogacy Contracts," *Journal of Family Law* 27 (1988-89), 634.

126. B.M. Knoppers and E. Sloss, "Recent Developments: Legislative Reforms in Reproductive Technology," *Ottawa Law Review* 18 (1986), 689-90, updated; B.M. Knoppers and S. Le Bris, "Recent Advances in Medically Assisted Conception: Legal, Ethical and Social Issues," *American Journal of Law and Medicine* 17 (1991): 329-61.

127. Lorio, *supra*, note 121, 1648.

128. S.G. Eisenman, "Fathers, Biological and Anonymous, and Other Legal Strangers: Determination of Parentage and Artificial Insemination by Donor Under Ohio Law," *Ohio State Law Journal* 45 (1984), 397.
129. J.M. Dwyer, "Equal Protection for Illegitimate Children Conceived by Artificial Insemination," *San Diego Law Review* 21 (1984), 1064.
130. *Ibid.*, 1066.
131. L.E. Harris, "Artificial Insemination and Surrogate Motherhood — A Nursery Full of Unresolved Questions," *Willamette Law Review* 17 (1981), 935.
132. One commentator argued that while the presumption of biology has operated legally to determine that the mother of the child is the one who gives it birth, there is an ambiguity in the meaning of the presumption. Although gestation may demonstrate motherhood, it is possible that the "common law viewed genetic consanguinity as the basis for maternal rights." It is possible that gestation was simply evidence of the genetic relationship. In the past the distinction was simply not of practical significance. Hill, *supra*, note 25, 370.
133. In the context of the donor insemination legislation, we have noted that intention has become a critical element in the attribution of paternal status.
134. M.D. Townsend, "Surrogate Mother Agreements: Contemporary Legal Aspects of a Biblical Notion," *University of Richmond Law Review* 16 (1982), 469.
135. P. Singer and D. Wells, *The Reproductive Revolution* (New York: Oxford University Press, 1984), 122, cited in Freedman, *supra*, note 15, 43.
136. Le Bris, *supra*, note 43, 40.
137. Dolgin argues that the surrender of parental rights by the gestational mother to the biological father in situations of surrogacy arrangements does not make surrogacy legally problematic. A woman can terminate her parental rights to her child, and the wife of the biological father can adopt the child. However, it is the commercial and contractual nature of surrogacy arrangements, which requires that the surrogate, as a provision of the contract, revoke her parental rights and obligations in return for the financial consideration, that raises significant legal issues. J.L. Dolgin, "Status and Contract in Surrogate Motherhood: An Illumination of the Surrogacy Debate," *Buffalo Law Review* 38 (1990), 526.
138. Note that in the American decision of *In the Matter of Baby M* 217 N.J. Super. 313, 537 A.2d 1128 [1987], the court of first instance held that it was in the best interests of the child to terminate the parental rights of the genetic/gestational mother. This decision was overturned by the New Jersey Supreme Court.
139. See section on custody and access.
140. Coleman, *supra*, note 16, 80.
141. Stumpf, *supra*, note 16, 196.
142. J.F. Williams, "Differential Treatment of Men and Women by Artificial Reproduction Statutes," *Tulsa Law Journal* 21 (1986), 471.
143. OLRC, *supra*, note 34, vol. 2, 283, recommendation 52.
144. K.L. Frey, "New Reproductive Technologies: The Legal Problem and a Solution," *Tennessee Law Review* 49 (1982), 331-32. This argument is framed in

the context of a discussion about the legality of the "surrogate" motherhood contract, but the logic is applicable in this context.

145. See section on custody and access for a discussion of this latter problem.

146. Long, *supra*, note 16, 97 — It is important to consider what the status of the embryo is: Can people own and therefore donate a living human entity? Does that entity have any rights in and of itself?

147. Le Bris, *supra*, note 43, 60.

148. *Parts, 5 février 1976, Dalloz 1976, 573; Douai, 12 janvier 1977, Dalloz 1979, I.R., 242*, cited by C. Labrusse-Riou, *Droit de la famille 1. Les personnes* (Paris: Masson, 1984), 94; cited by Le Bris, *supra*, note 43, 39, note 189.

149. A... c. L... [1982] C.S. 964; *Droit de la famille 77* [1983] C.S. 692, cited by Le Bris, *supra*, note 43, 39, note 190.

150. OLRC, *supra*, note 34, 277 recommendation 19(1); Australia: Victoria: Status of Children (Amendment Act, 1984, Principal Act No. 8602 as amended by No. 9863), ss. 10E(2)(a) and (3)(a); paragraph D.2, Queensland Report; Australia: South Australia: Family Relations Act Amendment Act, 1984 s. 10(c); see Knoppers and Sloss, *supra*, note 126, 706; É. Deleury, "Droit de la filiation et progrès scientifiques," in *Développements récents en droit de la santé* (1991) (Cowansville: Éditions Yvon Blais, 1991), 182; German Benda Commission (a commission jointly instituted by the Federal Minister of Justice and the Federal Minister of Research and Technology): "In all cases, family law assigns maternity of children born as a result of contractual agreements to the women who give birth to them. If commissioning parents want the child to be legally theirs, they should be required to adopt the child"; cited by R. Frank, "Federal Republic of Germany: New Thinking on Maintenance Obligations, Artificial Insemination and Conflict of Laws," *Journal of Family Law* 26 (1987-88), 107; Annas, *supra*, note 42, 51, further states: "The current legal presumption that the gestational (or birth) mother is the legal mother should remain. This gives the child and society certainty of identification at the time of birth (a protection for both mother and child), and also recognizes the biological fact that the gestational mother has contributed more of herself to the child than the genetic mother, and therefore has a greater biological investment and interest in it. If any agreements regarding transfer, relinquishing of parental rights, or adoption are to be made, they should be made only by the gestational mother, and only after she has had a reasonable time after the birth to consider all her and her child's options" (emphasis in original); Krause, *supra*, note 120, 203, states that in order to discourage surrogacy contracts there should be an irrebuttable presumption that a woman giving birth to a child is its legal mother.

151. The Ontario Law Reform Commission stipulates that "upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes," OLRC, *supra*, note 34, 283, recommendation 52; "The Arkansas artificial insemination statute originally denoted that a child born by means of AI to an unmarried woman shall be the child of the woman giving birth except in the case of a surrogate mother, in which case the child shall be that of the intended mother (Ark. Rev. Stat. §9-10-201 (1987)). The statute was amended in 1989 to enlarge the definition of a surrogate mother to include both married and unmarried women. It also expanded the class of legally recognized parents of a child born to a surrogate mother to include biological father and his

wife, the biological father alone if he is unmarried, and the woman intended to be the mother where the surrogate mother was artificially inseminated with an anonymous donor's sperm," cited in A.W. Latourette, "The Surrogate Mother Contract: In the Best Interests of Society?" *University of Richmond Law Review* 25 (1990-91), 77, note 92.

152. *Johnson v. Calvert*, where California Orange County Superior Court Judge Richard N. Parslow, Jr. ruled that the gestational mother had no rights with regard to the baby she bore for an infertile couple (*Anna J. v. Mark C.*, Calif. Ct. App. 4th Dist., No. G010255, 8 October 1991). See Gewertz, "Infant's Genetic Parents Win Rights over Surrogate Mother," *Philadelphia Inquirer* (23 October 1990), A-1, col. 1; *Smith v. Jones*, No. 85532014 DZ (Michigan Cir. Ct., Wayne County, 4 March 1986), cited in L.B. Andrews, "Surrogate Motherhood: Should the Adoption Model Apply?" *Children's Legal Rights Journal* 7 (4)(1986): 13-20.

153. H. de Billy, "Une révolution biologique," *Gazette des femmes* (Special Number) (29 October 1989), 6.

154. M. Nolin and H. Guay, "Le phénomène des femmes porteuses, le droit à l'écoute de la science et de la société," in *Réflexions juridiques sur le phénomène des femmes porteuses d'enfants* (Cowansville: Éditions Yvon Blais, 1985), 60; Le Bris, *supra*, note 43, 49.

155. S. O'Brien, "Commercial Conceptions: A Breeding Ground for Surrogacy," *North Carolina Law Review* 65 (1986-87), 140; see also L. Waller, "Borne for Another," *Monash University Law Review* 10 (1984), 114-15.

156. Andrews, *supra*, note 152, 18; other commentators also view the "but for" intention of the commissioning couple in a similar way: see Hill, *supra*, note 25, Robertson, *supra*, note 2, and Shultz, *supra*, note 1.

157. Freedman et al., *supra*, note 15, 36.

158. Le Bris, *supra*, note 43, 30.

159. Quebec, Conseil du statut de la femme, *General Opinion of the Conseil du statut de la femme in Regard to New Reproductive Technologies* (Quebec: Conseil du statut de la femme, 1989), 6.

160. *Ibid.*, 13.

161. *La Gazette des femmes* 8 (May-June 1986).

162. J.A. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction," *Law, Medicine and Health Care* 16 (1988), 20-21.

163. P.F. Silva-Ruiz, "Artificial Reproduction Techniques, Fertility Regulation: The Challenge of Contemporary Family Law," *American Journal of Comparative Law* 34 (1986), 130-31, note 29.

164. B.M. Dickens, "Artificial Reproduction and Child Custody," *Canadian Bar Review* 66 (1987), 51.

165. Section 215 of the Criminal Code, R.S.C. 1985, c. C-46, imposes a duty on the parent of a child to provide the necessities of life for a child under the age of 16. The Divorce Act, 1985, S.C. 1986, c. 4, s. 15(8), provides that spouses have a joint financial obligation to support a child of the marriage. Each of the provincial

jurisdictions also stipulates financial obligations of parents to support their child. (See section on support.)

166. *Parens patriae* "originates from the English common law where the King had a royal prerogative to act as guardian to persons with legal disabilities such as infants, idiots and lunatics." *Black's Law Dictionary*, *supra*, note 4, 1003.

167. *Canadian Family Law Guide* (Don Mills: Commerce Clearing House Canadian, 1991), 2551-3.

168. In British Columbia, Newfoundland, Ontario, Prince Edward Island, Quebec, and the Yukon, no distinction exists between the concepts of custody and guardianship; in Manitoba, the distinction between custody and guardianship is maintained and custody is construed to include only the care and control of the child, while guardianship includes the broader range of rights and responsibilities. See MANITOBA: The Child and Family Services Act, s. 77(4), and The Family Maintenance Act, s. 1. In Alberta, New Brunswick, Nova Scotia, the Northwest Territories, and Saskatchewan, while the legislation preserves the separate categories of custody and guardianship, there has been a tendency by the judiciary to construe custody broadly to include all of the rights and obligations associated with guardianship of the person, even though provincial legislation does not define custody to include the broad range of incidents associated with guardianship. See *Canadian Family Law Guide*, *supra*, note 167, 2554, para. 4620.

169. *Canadian Encyclopedic Digest* (Western), 3d ed., vol. 18 (February 1983), 77-231.

170. S.B. Boyd, "From Gender Specificity to Gender Neutrality? Ideologies in Canadian Child Custody Law," in *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen (London: Routledge, 1989), 130. It is interesting to note, as Susan Boyd does, that the creation of maternal rights of custody corresponds to a shift in social relations and occurred during a period of social transformation to urbanization and industrialization. This increasing recognition of maternal responsibility was by no means uniformly beneficial for women. "Paternal authority still took precedence ... [r]ecognition of maternal rights ... was linked to the increasing 'cult of domesticity' surrounding middle- and upper-class women. With fathers in these households becoming increasingly involved in the public sphere of business and commerce, women became the 'divinely appointed guardians of the family'" (*ibid.*, 131).

171. ALBERTA: Domestic Relations Act, s. 56(2); Provincial Court Act, R.S.A. 1980, c. P-20, s. 32(1); under the Domestic Relations Act the court must also consider the conduct of the parents and the wishes of the father and mother; BRITISH COLUMBIA: Family Relations Act, s. 24; Law and Equity Act, s. 47; MANITOBA: The Family Maintenance Act, s. 2(1), which act also provides that the child's views and preferences may be considered; NEW BRUNSWICK: Family Services Act, ss. 1 and 129(3); NEWFOUNDLAND: Children's Law Act, s. 31(1), s. 71; NORTHWEST TERRITORIES: Domestic Relations Act, R.S.N.W.T. 1988, c. D-8, s. 34(2), the court must also have regard to the conduct of the parents and the wishes of the father and the mother; NOVA SCOTIA: Family Maintenance Act, s. 18(5); Children's Services Act, ss. 68 and 77; Infant's Custody Act, R.S.N.S. 1989, c. 228, s. 3, the conduct or circumstances of the child's parents and the wishes of the father and mother must also be considered; ONTARIO: Children's Law Reform Act, s. 24(1); PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, R.S.P.E.I. 1988,

c. C-33, s. 15; QUEBEC: C.C.Q., art. 654; C.C.L.C., art. 30; SASKATCHEWAN: The Children's Law Act, s. 8; YUKON: Children's Act, s. 1.

172. ALBERTA: no factors are listed in the Domestic Relations Act or in the Provincial Court Act; BRITISH COLUMBIA: the Family Relations Act, s. 24(1), includes factors (a), (b), (d), and a variation on (e) and (h); MANITOBA: The Family Maintenance Act lists no factors; NEW BRUNSWICK: the Family Services Act, s. 1, includes factors (a), (b), and (d) in addition to the following factors: (1) the effect upon the child of any disruption of the child's sense of continuity, (2) the merits of any plan proposed by the minister under which he would be caring for the child, in comparison with the merits of the child returning to or remaining with his [sic] parents, (3) the need to provide a secure environment that would permit the child to become a useful and productive member of society through the achievement of his [sic] full potential according to his [sic] individual capacity, and (4) the child's cultural and religious heritage; NEWFOUNDLAND: the Children's Law Act, s. 31(2), includes factors (b) through (i); NORTHWEST TERRITORIES: the Domestic Relations Act lists no factors; NOVA SCOTIA: the Children's Services Act, the Family Maintenance Act, and the Infant's Custody Act list no factors; ONTARIO: the Children's Law Reform Act, s. 24(2), includes factors (b), (d), (e), (f), (g), (h), and (i); PRINCE EDWARD ISLAND: no factors are listed in the Custody Jurisdiction and Enforcement Act; QUEBEC: C.C.Q., art. 30, sets out "the child's age, sex, religion, language, character and family surroundings, and the other circumstances in which he lives"; SASKATCHEWAN: The Children's Law Act, s. 8, includes factors (a), (b), (d), (g), and (h). In addition, the legislation lists the following factors: (1) the plans that the person seeking custody has for the future of the child and (2) the social and economic needs of the child; YUKON: the Children's Act, s. 30(1), includes factors (b) through (g), in addition to "the effect that awarding custody or care of the child to one party would have on the ability of the other party to have reasonable access to the child."

173. *New Brunswick (Minister of Health and Community Services) v. G.(C.C.)*, [1988] 1 S.C.R. 1073 at 1080.

174. C. Davies, *Family Law in Canada* (Toronto: Carswell, 1984), 311.

175. ALBERTA: Domestic Relations Act, s. 47, provides, *inter alia*, that unless the court orders otherwise, an unmarried father must have cohabited with the mother of the child for at least one year before the birth of the child or married the mother after the birth of the child and acknowledge paternity to be recognized as guardian of the child. However, in *Kastning v. Charles et al.* (1987), 80 A.R. 150 (Q.B.), the court held that the Vital Statistics Act and s. 47 of the Domestic Relations Act operated together to make the natural father of a child the joint guardian where, at the joint request of the natural mother and father, the birth documentation under the Vital Statistics Act recognized the paternity of the father. See also *Walker v. Smith* (1987), 56 Alta. L.R. (2d) 285 (Q.B.); *Cardinal v. Cardinal* (1988), 62 Alta. L.R. (2d) 66 (Q.B.) and *Re L.G.A.B.* (1989), 101 A.R. 92 (Prov. Ct.) for a discussion of the mother's sole guardianship of an illegitimate child unless ordered by the court. BRITISH COLUMBIA: Family Relations Act, s. 27(5), provides that the mother is the sole guardian of her child where the father and mother have not been married to each other during the life of the child or 10 months before its [sic] birth; NEW BRUNSWICK: Guardianship of Children Act, R.S.N.B. 1973, c. G-8, s. 2(1), provides that parents of a child are joint guardians of a child; however, s. 1 states that

"parent" does not include the father of a child whose father and mother are not married to each other. In addition, pursuant to s. 3(1), a parent may lose his or her status as joint guardian if living separate and apart from his or her spouse and displaying through conduct an intention to abandon the child. NORTHWEST TERRITORIES: Domestic Relations Act, s. 22(4), provides that the mother is the sole guardian of the child unless the court orders otherwise, where the parents are living separate and apart and they were not married to each other or did not live together during the life of the child or 10 months before the birth of the child.

176. ALBERTA: Domestic Relations Act, ss. 47, 56, 61; BRITISH COLUMBIA: Family Relations Act, s. 34(1); MANITOBA: The Family Maintenance Act, s. 39(1)(2); NEW BRUNSWICK: Family Services Act, s. 129(1)(2); NEWFOUNDLAND: Children's Law Act, s. 26(1); NOVA SCOTIA: Children's Services Act, s. 68; ONTARIO: Children's Law Reform Act, s. 20; PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, s. 3; QUEBEC: C.C.Q., arts. 568, 570; SASKATCHEWAN: The Children's Law Act, s. 3; YUKON: Children's Act, s. 31.

177. While at common law the mother of an illegitimate child had a *prima facie* right to the custody of her child (see the decision of the Supreme Court of Canada in *Re Baby Duffell; Martin v. Duffell*, [1950] S.C.R. 737 at 746), the abolition of the status of illegitimacy in almost all Canadian provinces, it has been argued, upgrades the status of the fathers of children born outside legally sanctioned marriages and gives them an entitlement to custody equal to that of the mother.

178. ALBERTA: Domestic Relations Act, s. 47; BRITISH COLUMBIA: Family Relations Act, s. 27(5); NORTHWEST TERRITORIES: Domestic Relations Act, s. 22(4).

179. CANADA: Divorce Act, 1985, s. 16(4); BRITISH COLUMBIA: Family Relations Act, s. 35; MANITOBA: The Family Maintenance Act, s. 39(2)(c); NEW BRUNSWICK: Family Services Act, s. 129(2); NEWFOUNDLAND: Children's Law Act, s. 33(a); NOVA SCOTIA: Family Maintenance Act, s. 18(4), (5); ONTARIO: Children's Law Reform Act, s. 28(a); PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, s. 5(1)(a); SASKATCHEWAN: The Children's Law Act, s. 6(1)(a); YUKON: Children's Act, s. 33(2)(a).

180. CANADA: Divorce Act, 1985, s. 16(10); SASKATCHEWAN: The Children's Law Act, s. 6(5).

181. YUKON: Children's Act, s. 30(4): "In any proceedings in respect of custody of a child between the mother and the father of that child, there shall be a rebuttable presumption that the court ought to award the care of the child to one parent or the other and that all other parental rights associated with custody of that child ought to be shared by the mother and the father jointly."

182. For a thorough analysis of joint custody in Canadian law, see G.C. Colman, "Joint Custody: Recent Developments," *Canadian Family Law Quarterly* 4 (1989): 1-38.

183. ALBERTA: Domestic Relations Act, s. 50, permits a minor or anyone on his or her behalf to apply to the court for guardianship — note that this does not automatically mean custody; NEW BRUNSWICK: Family Services Act, s. 129(2); NEWFOUNDLAND: Children's Law Act, s. 27, in conjunction with s. 69(4) — the following individuals other than the child's mother or father have standing to apply for custody: "(b) a person who has demonstrated a settled intention to treat the

child as a child of his or her family; (c) a person who had the actual care and upbringing of the child before the application; and (d) another person whose presence as a party is necessary to determine the matters in issue"; NOVA SCOTIA: Children's Services Act, s. 68: "A parent or other person authorized by the Minister may make an application"; ONTARIO: Children's Law Reform Act, s. 21; PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, s. 4; QUEBEC: C.C.Q., art. 654; SASKATCHEWAN: The Children's Law Act, s. 6: "on the application of a parent or other person having, in the opinion of the court, a sufficient interest"; NORTHWEST TERRITORIES: Domestic Relations Act, s. 29(2); YUKON: Children's Act, s. 33.

184. *Re Baby Duffell*, *supra*, note 177; *Hepton v. Maat*, [1957] S.C.R. 606 at 615; *Re Agar; McNeillly v. Agar*, [1958] S.C.R. 52 ("the trilogy").

185. *King v. Low*, [1985] 1 S.C.R. 87 at 101; McIntyre J.'s decision includes a very thorough summary of the law of custody disputes between a parent and a non-parent, noting particularly the growing predominance of the welfare of the child over the rights of the parents.

186. *Hardcastle v. Huculak* (1987) [1988], 11 R.F.L. (3d) 363 (Sask. C.A.) at 366. This case involved the right of the young father of an illegitimate child to custody where the child's mother had consented to the child's adoption. The trial court had ruled in favour of the adoption; the appeal court over-ruled. See also a similar case of *M. (C.G.) v. W. (C.)* (1990), 23 R.F.L. (3d) 1, where the Court of Appeal for British Columbia awarded interim custody to the child's natural father and his parents over the adoptive parents who had had custody since shortly after the child's birth.

187. *Clapp v. Morin* (1991), 82 D.L.R. (4th) 353 at 359 (O.C.). In this case the dispute for custody was between the child's natural father and her maternal aunt and grandmother. Despite the fact that the child had lived with the latter for the prior 22 months, the court was convinced that both competing parties would provide for the child equally. Having determined this equality, the court decided that it would be in the long-term best interests of the child to be in the custody of her natural father. Cited with approval (with some confusion) by Granger J. of the Ontario Court, *Crocker v. Sipus* (1992), 41 R.F.L. (3d) 5.

188. NEWFOUNDLAND: Children's Law Act, s. 31(2)(h); ONTARIO: Children's Law Reform Act, s. 24(2)(g); Davies, *supra*, note 174, 313.

189. *C.(G.) v. V.-F.T.*, [1987] 2 S.C.R. 244; this case considered the meaning of article 654 of the C.C.Q. and article 30 of the C.C.L.C.

190. *Ibid.*, 281.

191. See, for example, *Moores v. Feldstein*, [1973] 3 O.R. 921 (C.A.); *Wiltshire v. Wiltshire* (1975), 20 R.F.L. 50 (Ont. H.C.); *McGee v. Waldern and Cunningham*, [1971] 4 W.W.R. 684 (Alta. S.C.); *M. (T.L.) v. F. (G.E.)* (1988), 60 Alta. L.R. (2d) 65 (C.A.); *Re Fitzpatrick* (1986), 57 Nfld. & P.E.I.R. 38 (Nfld. S.C.); *Rosta v. Thiel* (1986), 72 N.S.R. (2d) 33 (S.C.); *Gordon et al. v. Gordon* (1975) [1976], 20 R.F.L. 355 (Ont.); *Re Pamela A.* (1969) [1970], 1 N.S.R. (2d) 232 (S.C.); *Patton v. Patton* (1978), 1 F.L.R.A.C. 212 (Ont. Co. Ct.); *King v. Low*, *supra*, note 185.

192. (1992), 117 N.B.R. (2d) 402, 407-408 (Q.B.); cited with approval by Guerette J. in *McKay v. Sambles* (1992), 36 R.F.L. (3d) 383 (N.B.C.Q.B.).

193. *H.(F.V.) v. O.(D.A.)* (1988) 16 R.F.L. 430 (N.B.C.A.).

194. *Csicstri v. Csicstri* (1974) [1975], 17 R.F.L. 32 (Alta. S.C.), 32.
195. See, for example, *Bedard v. Bedard* (1984) [1985], 43 R.F.L. (2d) 331 (Man. C.A.); *Pike v. Pike* (1984), 38 R.F.L. (2d) 71 (Ont. H.C.).
196. See the following legislation for an enumeration of the rights of access: MANITOBA: The Family Maintenance Act, s. 39(4),(5); NEWFOUNDLAND: Children's Law Act, s. 26(6); ONTARIO: Children's Law Reform Act, s. 20(5); PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, s. 3(5); SASKATCHEWAN: The Children's Law Act, s. 9(2),(3); YUKON: Children's Act, s. 31(5),(6).
197. ALBERTA: Provincial Court Act, s. 32; BRITISH COLUMBIA: Family Relations Act, s. 35(1); MANITOBA: The Child and Family Services Act, s. 78, "in exceptional circumstances"; NEW BRUNSWICK: Family Services Act, s. 129(3); NEWFOUNDLAND: Children's Law Act, s. 27; NOVA SCOTIA: Family Maintenance Act, s. 18(2); ONTARIO: Children's Law Reform Act, s. 21; PRINCE EDWARD ISLAND: Custody Jurisdiction and Enforcement Act, s. 4; SASKATCHEWAN: The Children's Law Act, s. 6(1); YUKON: Children's Act, s. 33(1).
198. *Driaunevictus v. Wilson* (1990), 25 R.F.L. (3d) 85 (Man. Q.B.), appeal dismissed (1991), 30 R.F.L. (3d) 267 (Man. C.A.).
199. See *Cyrenne v. Moar* (1986), 2 R.F.L. (3d) 414 (Man. C.A.); *Lapp v. Dupuis* (1985), 45 R.F.L. (2d) 23 (Man. C.A.); *Milne v. Milne* (1985), 44 R.F.L. (2d) 241 (B.C.C.A.); *Scott v. Hotchkiss* (1990), 26 R.F.L. (3d) 26 (Alta. Prov. Ct.); *Fishburne v. Eggleton* (1987) [1988], 12 R.F.L. (3d) 251 (B.C.S.C.).
200. ALBERTA: Domestic Relations Act, ss. 27, 56, Maintenance Order Act, R.S.A. 1980, c. M-1, ss. 1, 2, 3; Maintenance and Recovery Act, R.S.A. 1980, c. M-2; BRITISH COLUMBIA: Family Relations Act; MANITOBA: The Family Maintenance Act; NEW BRUNSWICK: Family Services Act; NEWFOUNDLAND: Family Law Act, R.S. Nfld. 1990, c. F-2, Children of Unmarried Parents Act, R.S.Nfld. 1970, c. 38; NORTHWEST TERRITORIES: Maintenance Act, R.S.N.W.T. 1988, c. M-1, Child Welfare Act; NOVA SCOTIA: Family Maintenance Act; ONTARIO: Family Law Act, R.S.O. 1990, c. F.3; Children's Law Reform Act; PRINCE EDWARD ISLAND: Child Status Act, Family Law Reform Act, R.S.P.E.I. 1988, c. F-3; QUEBEC: C.C.Q., art. 647; SASKATCHEWAN: The Family Maintenance Act, S.S. 1990-91, c. F-6.1, The Children of Unmarried Parents Act; YUKON: Family Property and Support Act, R.S.Y. 1986, c. 63, Children's Act.
201. *Patton v. Patton* (1982), 27 R.F.L. (2d) 202 (N.S.S.C.); *Tuaddle v. Tuaddle* (1985), 46 R.F.L. (2d) 337 (N.S.S.C.).
202. *C.M. v. C.C.* 377 A.2d 821 (1977 N.J. Sup. Ct.).
203. *Jhordan C. v. Mary K.*, 224 Cal. Rptr. 530 (1986 Cal. Ct. App.).
204. See, for example, M.A. Field, *Surrogate Motherhood* (Cambridge: Harvard University Press, 1988), 116; S.A. Radke, "Law, Liberty and Childbearing at the Turn of the Century: Maternal Liability, Surrogate Motherhood and Donated Genetic Material" (Calgary: Alberta Civil Liberties Research Centre, 1990), 112; B. Kritchevsky, "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family," *Harvard Women's Law Review* 4 (1981): 1-42; Polikoff, *supra*, note 122, 468.
205. See, for example, *King v. Ward* (1984), 41 R.F.L. (2d) 98 (Ont. Prov. Ct.).

206. See *Kristoff v. Kristoff* (1987), 59 O.R. (2d) 464 (D.C.), where the court held that a husband cannot demonstrate a settled intention to treat as his own a child of whom he is not the natural father even if he has been led to believe, as a result of his wife's deceit, that he is the natural father of the child.
207. *Anderson v. Luoma* (1986), 50 R.F.L. (2d) 127 at 140 (B.C.S.C.).
208. Ibid. Note that in a number of American cases, custody and/or access and an obligation of support have been attributed to the non-legal parent of a child in a lesbian relationship; see Field, *supra*, note 204, 115. See also Polikoff, *supra*, note 122, for an interesting and provocative discussion of the establishment of the parental status of the non-genetic/gestational lesbian mother. While she notes that the rights of custody and access were awarded in some cases to a lesbian partner where the genetic/gestational mother had died or the lesbian partners had separated, in no case was the non-genetic/gestational lesbian mother granted parental status. Therefore, in each case a protracted court battle ensued.
209. *Shtitz v. C.N.R.*, [1927] 1 D.L.R. 959 (Sask. C.A.).
210. CANADA: Divorce Act, R.S.C. 1985 (2nd Supp.), c. 3, s. 2.
211. For a discussion of the recent case law regarding the right to terminate the intention to act as a parent, see K.B. Farquhar, "Termination of the "*In Loco Parentis*" Obligation of Child Support," *Canadian Journal of Family Law* 9 (1990-91): 99-130.
212. 160 Mich. App. 601, 408 N.W. 2d 516 (1987).
213. Ibid., 608-609, 408 N.W. 2d at 519, cited in Polikoff, *supra*, note 122, 484.
214. Polikoff, *ibid.*, 485.
215. *Black's Law Dictionary*, *supra*, note 4, 710.
216. See, for example, *Gursky v. Gursky* 39 Misc. 2d 1083, 242 N.Y.S. 2d 406 (Sup. Ct. 1963); and *Wener v. Wener* 35 A.D. 2d 50, 312 N.Y.S. 2d 815 (1970), which dealt with a situation where a couple agreed to adopt a child and the prospective father left the family home prior to finalization of the adoption proceeding; cited in Polikoff, *supra*, note 122, 492-93.
217. Polikoff, *ibid.*, 498. Polikoff cites a number of cases where this doctrine is so used; *ibid.*, 495 *et seq.*
218. *Sabol v. Bowling*, No. CF-27,024 (Cal. Super. Ct., Los Angeles Cty., 30 January 1989); Memorandum Opinion at 1-2, *Carney v. Diana*, No. 89,191,039-CE 99,949 (Baltimore City Cir. Ct., 11 January 1990), cited in Polikoff, *ibid.*, 491.
219. Polikoff, *ibid.*, 499.
220. *In the matter of Baby M.*, *supra*, note 138; Russell, *supra*, note 125, 654.
221. Coleman, *supra*, note 16, 90.
222. See, for example, R. Mnookin, "Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy," *Law and Contemporary Problems* 39 (1975), 229; D.L. Chambers, "Rethinking the Substantive Rules for Custody Disputes in Divorce," *Michigan Law Review* 83 (1984): 477-569; D. Duff and R. Mykitiuk, "Parental Separation and the Child Custody Decision: Toward a Reconceptualization," *University of Toronto Faculty of Law Review* 47 (Suppl.) (1989), 904.
223. Mnookin, *ibid.*, 255-61; Duff and Mykitiuk, *ibid.*, 904.

224. *Ibid.*
225. Duff and Mykitiuk, *supra*, note 222, 937; Field, *supra*, note 204, 126.
226. Field, *supra*, note 204, 134.
227. See, for example, Field, *ibid.*, 131, and R.A. Charo, "Legislative Approaches to Surrogate Motherhood," *Law, Medicine and Health Care* 16 (1988): 96-112.
228. See, for example, Field, *ibid.*, 132; Russell, *supra*, note 125, 654.
229. Coleman, *supra*, note 16, 98-100.
230. Veevers, *supra*, note 23, 297.
231. W.J. Wagner, "The Ethical and Legal Implications of Hired Maternity," *American Journal of Jurisprudence* 35 (1990), 193. His formulation stems from a Catholic analysis of the family.
232. *Ibid.*, 193, note 16, citing *Pastoral Constitution*, 254.
233. *Ibid.*, 193.
234. Long, *supra*, note 16, 89.
235. Dolgin, *supra*, note 137.
236. Wagner, *supra*, note 231, 201.
237. *Ibid.*, 202.
238. *Ibid.*
239. *Canada (A.G.) v. Mossop*, [1991] 1 F.C. 18 (C.A.) (leave granted 25 January 1991, SCC Bulletin, p. 157, No. 23145).
240. *Canada (A.G.) v. Mossop*, S.C.C. 25 February 1993 (unreported) case no. 22145.
241. The *Toronto Star* ran an article on the legal battle commenced by Todd Layland and Pierre Beaulne. "Gay Couple Go to Court for Marriage Licence," *Toronto Star* (2 December 1992): A11.
242. "Two Men Can't Be Married Court Says," *Toronto Star* (16 March 1993): A2.
243. *Douglas v. The Queen*, 1 December 1992, (FCA) Court File No.: T-160-90.
244. "[S]he was ineligible for promotion, for conversion of her existing terms of service, for posting outside the geographic area, for transfer to the reserve force or for any further qualification courses or training except that required to carry out restricted employment." *Ibid.*, 3.
245. *Ibid.*
246. *Canadian Charter of Rights and Freedoms*, s. 15(1), Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.
247. *Halig v. Canada* (1992), 9 O.R. (3d) 495 at 496-97 (Ont. C.A.). There, McDonald J. ruled that the "absence of sexual orientation from the list of proscribed grounds of discrimination in s. 3 of the *Canadian Human Rights Act*, R.S.C. 1985, c. H-6, is discriminatory as being contrary to the guarantee of equal benefit of the law set out in s. 15 of the *Canadian Charter of Rights and Freedoms*."
248. Bill C-108, An Act to Amend the Canadian Human Rights Act and other Acts in consequence thereof, s. 10 amending s. 25 of the said act.

249. B. De Mara, "Metro's 300,000 Gays, Lesbians Struggle for Respect," *Toronto Star* (8 August 1992): A1, A10.
250. For an interesting review of family law as it relates to homosexuals, please see B. Ryder, "Equality Rights and Sexual Orientation: Confronting Heterosexual Family Privilege," *Canadian Journal of Family Law* 9 (1990-91): 39-97.
251. A.S. Lopez, "Test Tube Babies, Surrogate Mothers, Frozen Embryos: Searching for Solutions," *New Mexico Law Review* 20 (1990), 711.
252. Shultz, *supra*, note 1, 332.
253. Stumpf, *supra*, note 16, 196.
254. See Robertson, *supra*, notes 2, 162; Hill, *supra*, note 25; Shultz, *supra*, note 1; contra B. Jensen, "Artificial Insemination and the Law," *Brigham Young University Law Review* (1982): 935-90; Ryan, *supra*, note 24; Russell, *supra*, note 125; etc.
255. This would be more likely to occur in the United States, where legislation requires a man to assume financial responsibility for his children if the child's mother and the child seek financial assistance from the state. See the next section for further analysis of the single parent/homosexual couple's access to AID.
256. Shultz, *supra*, note 1, 323; see also Stumpf, *supra*, note 16.
257. Hill, *supra*, note 25, 415.
258. Stumpf, *supra*, note 16, 205.
259. *Ibid.*, 195-96.
260. Shultz, *supra*, note 1, 302-303.
261. Stumpf, *supra*, note 16, 194.
262. Ryan, *supra*, note 24, 9.
263. Dolgin, *supra*, note 137, 523.
264. *Ibid.*
265. Ryan, *supra*, note 24, 9.
266. *Ibid.*
267. *Ibid.*
268. This latter option creates all sorts of risks for both the woman and the resulting child. No tests will be conducted on the sperm to screen for human immunodeficiency virus (HIV) or any genetic conditions. The fact that genetic problems arise without screening in the context of the traditional family does not mean that we should permit no screening when there is potentially no relationship between the donor and the parent of the child.
269. OLRC, *supra*, note 34, vol. 1, 102.
270. *Ibid.*, 107.
271. Charo, *supra*, note 227, 103.

Bibliography

Books, Articles, Reports

- Abbas, J., et al. "Model Human Reproductive Technologies and Surrogacy Act: An Act Governing the Status of Children Born Through Reproductive Technologies and Surrogacy Arrangements." *Iowa Law Review* 72 (1986-87): 943-1013.
- Allen, A.L. "Surrogacy, Slavery, and the Ownership of Life." *Harvard Journal of Law and Public Policy* 13 (1990): 139-49.
- Andrews, L.B. "The Stork Market: Legal Regulation of the New Reproductive Technologies." *Whittier Law Review* 6 (1984): 789-98.
- . "Surrogate Motherhood: Should the Adoption Model Apply?" *Children's Legal Rights Journal* 7 (4)(1986): 13-20.
 - . "When Baby's Mother Is also Grandma — and Sister." *Hastings Center Report* 15 (October 1985): 29-30.
- Annas, G.J. "Baby M: Babies (and Justice) for Sale." *Hastings Center Report* 11 (June 1987): 13-15.
- . "Contracts to Bear a Child: Compassion or Commercialism?" *Hastings Center Report* 11 (April 1981): 23-24.
 - . "Fathers Anonymous: Beyond the Best Interests of the Sperm Donor." *Family Law Quarterly* 14 (1980-81): 1-13.
 - . "Redefining Parenthood and Protecting Embryos: Why We Need New Laws." *Hastings Center Report* 14 (October 1984): 50-52.
- Annas, G.J., and E. Elias. "In Vitro Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family." *Family Law Quarterly* 17 (1983-84): 199-223.
- Ariès, P. *Centuries of Childhood: A Social History of Family Life*. New York: Vintage, 1962.
- Atherton, R.F. "Artificially Conceived Children and Inheritance in New South Wales." *Australian Law Journal* 60 (1986): 374-86.
- Australia. Family Law Council. "Creating Children — A Uniform Approach to the Law and Practice of Reproductive Technology in Australia." Canberra: Australian Government Publishing Service, 1985.
- Australia. Parliament Senate. Standing Committee on Constitutional and Legal Affairs on National Uniformity in Laws Relating to the Status of Children Born Through the Use of *In Vitro* Fertilisation. "IVF and the Status of Children: Report." Canberra: Australian Government Publishing Service, 1985.
- Barnett, D.L. "In Vitro Fertilization: Third Party Motherhood and the Changing Definition of Legal Parent." *Pacific Law Journal* 17 (1985): 231-59.
- Barreau du Québec. Comité sur les nouvelles technologies de reproduction. *Rapport*. Montreal: Le Barreau, 1988.
- Barrière, S. "Les actes de naissances: qui peut déclarer et quoi." *Revue du Barreau* 49 (1989): 165.
- Bartlett, K.T. "Re-Expressing Parenthood." *Yale Law Journal* 98 (1988): 293-340.

- Beck-Gernsheim, E. "The Changing Duties of Parents: From Education to Bio-Engineering?" *International Social Science Journal* 42 (1990): 451-63.
- Billy, H. de. "Une revolution biologique." *Gazette des femmes* (Special Number) (29 October 1989).
- Bissett-Johnson, A., and C.J. Cavett. "The Legacy of Baby M: Drafting and Contractual Problems." *Canadian Family Law Quarterly* 2 (1987): 299-342.
- Black, H.C. *Black's Law Dictionary*. 5th ed. St. Paul: West Publishing, 1979.
- Blumberg, G.G. "Legal Issues in Nonsurgical Human Ovum Transfer." *JAMA* 251 (1984): 1178-81.
- Borowyk, L. "The Family and the Legal System." Ottawa: Health and Welfare Canada, 1986.
- Bowal, P. "Surrogate Procreation: A Motherhood Issue in Legal Obscurity." *Queen's Law Journal* 9 (1983): 5-34.
- Bowie, W.D. "Multiplication and Division — New Math for the Courts: New Reproductive Technologies Create Potential Legal Time Bombs." *Dickinson Law Review* 95 (1990): 155-81.
- Boyd, S.B. "From Gender Specificity to Gender Neutrality? Ideologies in Canadian Child Custody Law." In *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen. London: Routledge, 1989.
- Brodrribb, S. "Reproductive Technologies, Masculine Dominance and the Canadian State." Toronto: Ontario Institute for Studies in Education, 1984.
- Brodsky, A.M. "Donating Babies to Create Families: Psychologists as Gatekeepers." Paper presented at the 95th American Psychological Association Annual Convention, New York, 28 August 1987.
- Brophy, K.M. "A Surrogate Mother Contract to Bear a Child." *Journal of Family Law* 20 (1981-82): 263-91.
- Brown, H., et al. "Legal Rights and Issues Surrounding Conception, Pregnancy and Birth." *Vanderbilt Law Review* 39 (1986): 597-850.
- Canadian Encyclopedic Digest* (Western). 3d ed. Vol. 18 (February 1983): 77-231 - 77-314.
- Canadian Family Law Guide*. Don Mills: Commerce Clearing House Canadian, 1991.
- Carbone, J.R. "The Role of Contract Principles in Determining the Validity of Surrogacy Contracts." *Santa Clara Law Review* 28 (1988): 581-610.
- Castelli, M.D. *Précis du droit de la famille*. Quebec: Presses de l'Université Laval, 1987.
- CCH. *Droit de la famille québécoise*, "Rapport no. 81." Farnham: Éditions FM, 27 January 1992.
- Chambers, D.L. "Rethinking the Substantive Rules for Custody Disputes in Divorce." *Michigan Law Review* 83 (1984): 477-569.
- Charo, R.A. "Legislative Approaches to Surrogate Motherhood." *Law, Medicine and Health Care* 16 (1988): 96-112.

- Christiaens, M. "Artificial Insemination by Donor and the View of Man." *European Journal of Obstetrics & Gynecology and Reproductive Biology* 28 (1988): 347-52.
- Clark, N.L. "New Wine in Old Skins: Using Paternity-Suit Settlements to Facilitate Surrogate Motherhood." *Journal of Family Law* 25 (1986-87): 483-527.
- Cohen, B. "Surrogate Mothers: Whose Baby Is It?" *American Journal of Law and Medicine* 10 (1984-85): 243-95.
- Coleman, M.N. "Embryo Transplant, Parental Conflict, and Reproductive Freedom: A Prospective Analysis of Issues and Arguments Created by Forthcoming Technology." *Hofstra Law Review* 15 (1986-87): 609-30.
- Coleman, P. "Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions." *Tennessee Law Review* 50 (1982): 71-119.
- Collier J., M.Z. Rosaldo, and S. Yanagisako. "Is There a Family: New Anthropological Views." In *Rethinking the Family: Some Feminist Questions*, ed. B. Thorne. New York: Longman, 1982.
- Colman, G.C. "Joint Custody: Recent Developments." *Canadian Family Law Quarterly* 4 (1989): 1-38.
- Coulter, R. "Perspectives on Motherhood: A Review Essay." *Atlantis* 10 (1985): 127-37.
- Crabtree, E. "Protecting Inheritance Rights of Children Born Through In Vitro Fertilization and Embryo Transfer: Suggestions for a Legislative Approach." *Saint Louis University Law Journal* 27 (1983): 901-28.
- Davies, C. *Family Law in Canada*. Toronto: Carswell, 1984.
- Davis, T.L. "Protecting the Cryopreserved Embryo." *Tennessee Law Review* 57 (1989-90): 507-37.
- Deleury, É. "Droit de la filiation et progrès scientifiques." In *Développements récents en droit de la santé* (1991). Cowansville: Éditions Yvon Blais, 1991.
- . "La personne en son corps: L'éclatement du sujet." *Canadian Bar Review* 70 (1991): 448-72.
- De Mara, B. "Metro's 300,000 Gays, Lesbians Struggle for Respect." *Toronto Star* (8 August 1992): A1, A10.
- De Stoop, D.F.J.J. "Human Artificial Insemination and the Law in Australia." *Australian Law Journal* 50 (1976): 298-308.
- Devlin, R.F. "Baby M: The Contractual Legitimation of Misogyny." 10 R.F.L. (3d) 1988: 4-29.
- Dickens, B.D. "Artificial Reproduction and Child Custody." *Canadian Bar Review* 66 (1987): 49-75.
- Dolgin, J.L. "Status and Contract in Surrogate Motherhood: An Illumination of the Surrogacy Debate." *Buffalo Law Review* 38 (1990): 515-50.
- Doren, R.J. "The Need for Regulation of Artificial Insemination by Donor." *San Diego Law Review* 22 (1985): 1193-1218.

- Duff, D.G., and R. Mykitiuk. "Parental Separation and the Child Custody Decision: Toward a Reconciliation." *University of Toronto Faculty of Law Review* 47 (Suppl.)(1989): 874-938.
- Dunnigan, L., and L. Barnard. "Nouvelles technologies de la reproduction: analyses et questionnements féministes." Québec: Conseil du statut de la femme, 1986.
- Durant, M.R. "Cryopreservation of Human Embryos: A Scientific Advance, a Judicial Dilemma." *Suffolk University Law Review* 24 (1990): 707-42.
- Dwyer, J.M. "Equal Protection for Illegitimate Children Conceived by Artificial Insemination." *San Diego Law Review* 21 (1984): 1061-75.
- Eggen, J.M. "The 'Orwellian Nightmare' Reconsidered: A Proposed Regulatory Framework for the Advanced Reproductive Technologies." *Georgia Law Review* 25 (1)(1990-91): 625-710.
- Eichler, M. *Families in Canada Today: Recent Changes and Their Policy Consequences*. Toronto: Gage, 1983.
- Eisenman, S.G. "Fathers, Biological and Anonymous, and Other Legal Strangers: Determination of Parentage and Artificial Insemination by Donor Under Ohio Law." *Ohio State Law Journal* 45 (1984): 383-98.
- Endicott, O. "The Right to Raise Children." *Entourage* 4 (Autumn 1989): 10.
- Farquhar, K.B. "Termination of the "In Loco Parentis" Obligation of Child Support." *Canadian Journal of Family Law* 9 (1990-91): 99-130.
- Faulkner, E. "The Case of 'Baby M.'" *Canadian Journal of Women and the Law* 3 (1989-90): 239-45.
- Field, M.A. *Surrogate Motherhood*. Cambridge: Harvard University Press, 1988.
- Flaherty, J.T. "Enforcement of Surrogate Mother Contracts: Case Law, the Uniform Acts, and State and Federal Legislation." *Cleveland State Law Review* 36 (1987-88): 223-51.
- Frank, R. "Federal Republic of Germany: New Thinking on Maintenance Obligations, Artificial Insemination and Conflict of Laws." *Journal of Family Law* 26 (1987-88): 101-11.
- Freedman, B., et al. "Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices." *Canadian Family Law Quarterly* 3 (1988): 35-54.
- Frey, K.L. "New Reproductive Technologies: The Legal Problem and a Solution." *Tennessee Law Review* 49 (1982): 303-42.
- Garcia, S.A. "Reproductive Technology for Procreation, Experimentation, and Profit." *Journal of Legal Medicine* 11 (1990): 1-57.
- "Gay Couple Go to Court for Marriage Licence." *Toronto Star* (2 December 1992): A11.
- Gewertz. "Infant's Genetic Parents Win Rights over Surrogate Mother." *Philadelphia Inquirer* (23 October 1990): A-1.
- Gibson, E.L. "Artificial Insemination by Donor: Information, Communication and Regulation." *Journal of Family Law* 30 (1991-92): 1-44.

- Glendon, M.A. *The New Family and the New Property*. 2d ed. Toronto: Butterworths, 1981.
- Goldberg, S. "Of Gametes and Guardians: The Impropriety of Appointing Guardians Ad Litem for Fetuses and Embryos." *Washington Law Review* 66 (1991): 503-44.
- Goldfarb, C. "Two Mothers, One Baby, No Law." *Human Rights* 11 (Summer 1983): 27-29, 54-56.
- Goldstein, J., A.J. Solnit, and A. Freud. *Beyond the Best Interests of the Child*. New York: Free Press, 1973.
- Greco, P.J. "Parental Guidance Suggested: A Proposal for Regulating Surrogate Parenthood." *Columbia Journal of Law and Social Problems* 22 (1988-89): 115-80.
- Hanscombe, G. "The Right to Lesbian Parenthood." *Journal of Medical Ethics* 9 (1983): 133-35.
- Harris, L.E. "Artificial Insemination and Surrogate Motherhood — A Nursery Full of Unresolved Questions." *Willamette Law Review* 17 (1981): 913-52.
- Heard, L.D. "A Time to Be Born, a Time to Die: Alternative Reproduction and Texas Probate Law." *St. Mary's Law Journal* 17 (1985-86): 927-63.
- Hill, J.L. "What Does It Mean to Be a 'Parent'? The Claims of Biology as the Basis for Parental Rights." *New York University Law Review* 66 (1991): 353-420.
- Hogg, P.W. *Constitutional Law of Canada*. 2d ed. Toronto: Carswell, 1985.
- Holland, W.H. *Unmarried Couples — Legal Aspects of Cohabitation*. Toronto: Carswell, 1982.
- Hovius, B. *Family Law: Cases, Notes and Materials*. 2d ed. Toronto: Carswell, 1987.
- "Infant's Genetic Parents Win Rights over Surrogate Mother." *Philadelphia Inquirer* (23 October 1990): A-1.
- Jansen, R.P.S. "Sperm and Ova as Property." *Journal of Medical Ethics* 11 (1985): 123-26.
- Jean, A. "Nouvelles technologies de la reproduction: pratiques cliniques et expérimentales au Québec." Quebec: Conseil du statut de la femme, 1986.
- Jensen, B. "Artificial Insemination and the Law." *Brigham Young University Law Review* (1982): 935-90.
- Jones, D. "Artificial Procreation, Societal Reconceptions: Legal Insight from France." *American Journal of Comparative Law* 36 (1988): 525-45.
- Kaiser, D.S. "Artificial Insemination: Donor Rights in Situations Involving Unmarried Recipients." *Journal of Family Law* 26 (1987-88): 793-811.
- Kiernan, K.E. "The British Family: Contemporary Trends and Issues." *Journal of Family Issues* 9 (1988): 298-316.
- Kirby, M.D. "Medical Technology and New Frontiers of Family Law." *Law, Medicine and Health Care* 14 (1986): 113-19.

- Kluge, E.-H.W., and C. Lucock. "New Human Reproductive Technologies: A Preliminary Perspective of the Canadian Medical Association." Ottawa: CMA, 1991.
- Knoppers, B.M. "The 'Legitimization' of Artificial Insemination: Promise or Problem?" *Family Law Review* 1 (1978): 108-17.
- . "Modern Birth Technology and Human Rights." *American Journal of Comparative Law* 33 (1985): 1-31.
- . "Reproductive Technology and International Mechanisms of Protection of the Human Person." *McGill Law Journal* 32 (1986-87): 336-58.
- . "Women and the Reproductive Technologies." In *Family Law in Canada: New Directions*, ed. E. Sloss. Ottawa: Canadian Advisory Council on the Status of Women, 1985.
- Knoppers, B.M., and S. Le Bris. "Recent Advances in Medically Assisted Conception: Legal, Ethical and Social Issues." *American Journal of Law and Medicine* 17 (1991): 329-61.
- Knoppers, B.M., and E. Sloss. "Legislative Reforms in Reproductive Technology." *Ottawa Law Review* 18 (1986): 663-719.
- Kolata, G. "When Grandma Is the Mother, Until Birth." *New York Times* (5 August 1991): A1, A11.
- Krause, H.D. "Artificial Conception: Legislative Approaches." *Family Law Quarterly* 19 (1985): 185-206.
- Kritchevsky, B. "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family." *Harvard Women's Law Review* 4 (1981): 1-42.
- Kymlicka, W. "Rethinking the Family." *Philosophy and Public Affairs* 20 (1991): 77-97.
- Labrusse-Riou, C. *Droit de la famille 1. Les personnes*. Paris: Masson, 1984.
- . "La filiation et la médecine moderne." *Revue Internationale de droit comparé* 38 (1986): 419-40.
- Lacey, L.J. "The Law of Artificial Insemination and Surrogate Parenthood in Oklahoma: Roadblocks to the Right to Procreate." *Tulsa Law Journal* 22 (1987): 281-324.
- Latourette, A.W. "The Surrogate Mother Contract: In the Best Interests of Society?" *University of Richmond Law Review* 25 (1990-91): 53-92.
- Law Reform Commission of Canada. *Medically Assisted Procreation*. Working Paper 65. Ottawa: LRC, 1992.
- Le Bris, S. "Procréation assistée et parentalité en droit français et québécois." L.L.M. thesis, Université de Montréal, 1988.
- Levine, R. "My Body, My Life, My Baby, My Rights." *Human Rights* 12 (Spring 1984): 46-50.
- Lodrup, P. "Norway: Reforming the Law of Matrimonial Property and Maintenance and Artificial Insemination." *Journal of Family Law* 27 (1988-89): 253-60.

- Long, L.L. "Artificially Assisted Conception." *Health Law in Canada* 5 (1985): 89-107.
- Lopez, A.S. "Privacy and the Regulation of the New Reproductive Technologies: A Decision-Making Approach." *Family Law Quarterly* 22 (1988-89): 173-97.
- . "Test Tube Babies, Surrogate Mothers, Frozen Embryos: Searching for Solutions." *New Mexico Law Review* 20 (1990): 701-12.
- Lorio, K.V. "Alternative Means of Reproduction: Virgin Territory for Legislation." *Louisiana Law Review* 44 (1984): 1641-76.
- McEwen, J.E. "R. McG. & C.W. v. J.W. & W.W.: The Putative Father's Right to Standing to Rebut the Marital Presumption of Paternity." *Northwestern University Law Review* 76 (1981-82): 669-708.
- Macklin, R. "Artificial Means of Reproduction and Our Understanding of the Family." *Hastings Center Report* 21 (January-February 1991): 5-11.
- McVey, W.W., Jr. "Emerging Nontraditional Family and Household Forms." Ottawa: Health and Welfare Canada, 1986.
- Mallory, T.E., and K.E. Rich. "Human Reproductive Technologies: An Appeal for Brave New Legislation in a Brave New World." *Washburn Law Journal* 25 (1985-86): 458-504.
- Mandell, N., and A. Duffy, eds. *Reconstructing the Canadian Family: Feminist Perspectives*. Toronto: Butterworths, 1988.
- Mandler, J.J. "Developing a Concept of the Modern 'Family': A Proposed Uniform Surrogate Parenthood Act." *Georgetown Law Journal* 73 (1984-85): 1283-1329.
- Mason, J.K. *Medico-Legal Aspects of Reproduction and Parenthood*. Aldershot: Dartmouth, 1990.
- Mason, J.K., and R.A. McCall Smith. *Law and Medical Ethics*. London: Butterworths, 1983.
- Mellow, M.R. "An Incomplete Picture: The Debate About Surrogate Motherhood." *Harvard Women's Law Journal* 8 (1985): 231-46.
- Migneault, P.B. *Le droit civil canadien*. Montreal: Whiteford and Théoret, 1895.
- Miller, S.L. "Surrogate Parenthood and Adoption Statutes: Can a Square Peg Fit into a Round Hole?" *Family Law Quarterly* 22 (1988-89): 199-212.
- Minow, M. "Redefining Families: Who's In and Who's Out?" *University of Colorado Law Review* 62 (1991): 269-85.
- Mitchell, A. "Marriages in Decline, Data Show." *Globe and Mail* (24 April 1992): A20.
- Mnookin, R. "Child-Custody Adjudication — Judicial Functions in the Face of Indeterminacy." *Law and Contemporary Problems* 39 (1975): 226-93.
- Montgomery, J. "Children as Property?" *Modern Law Review* 51 (1988): 323-42.
- . "Constructing a Family — After a Surrogate Birth." *Modern Law Review* 49 (1986): 635-40.
- . "Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990." *Modern Law Review* 54 (1991): 524-34.

- Morgan, D. "Making Motherhood Male: Surrogacy and the Moral Economy of Women." *Journal of Law and Society* 12 (1985): 219-38.
- "National Conference on Birth, Death, and Law." *Jurimetrics Journal* 29 (1988-89): 403-36.
- Nolin, M., and H. Guay. "Le phénomène des femmes porteuses: le droit a l'écoute de la science et de la société." In *Reflexions juridiques sur le phénomène des femmes porteuses d'enfants*. Cowansville: Éditions Yvon Blais, 1985.
- O'Brien, S. "Commercial Conceptions: A Breeding Ground for Surrogacy." *North Carolina Law Review* 65 (1986-87): 126-53.
- Okin, S.M. *Justice, Gender, and the Family*. New York: Basic Books, 1989.
- Oliver, D. *Cohabitation: The Legal Implications*. Bicester: CCH Editions, 1987.
- Olsen, F.E. "The Family and the Market: A Study of Ideology and Law Reform." *Harvard Law Review* 96 (1982-83): 1497-1578.
- Ontario Law Reform Commission. "Report on Human Artificial Reproduction and Related Matters." Toronto: Ontario Ministry of the Attorney General, 1985.
- Overall, C. "Sexuality, Parenting, and Reproductive Choices." Kingston: Queen's University; Department of Philosophy, 1986.
- Parker, D.C. "Legal Aspects of Artificial Insemination and Embryo Transfer." *Family Law* 12 (1982): 103-107.
- Payne, V.L. "The Regulation of Surrogate Motherhood." *Family Law* 17 (1987): 178-80.
- Pieper, M.A. "Frozen Embryos — Persons or Property? Davis v. Davis." *Creighton Law Review* 23 (1989-90): 807-33.
- Pineau, J. "Les preuves de la filiation." *Cahiers de Droit* 22 (1981): 337-46.
- Polikoff, N.D. "This Child Does Have Two Mothers: Redefining Parenthood to Meet the Needs of Children in Lesbian-Mother and Other Nontraditional Families." *Georgetown Law Journal* 78 (1990): 459-575.
- Poole, E.K. "Allocation of Decision-Making Rights to Frozen Embryos." *American Journal of Family Law* 4 (1990): 67-102.
- Pratte, M. "La présomption de paternité: complice ou rivale de l'acte de naissance." *Revue générale de droit* 17 (1986): 685-702.
- Pratte, M., and E. Monjal. "Présomption de paternité et vérité biologique en droit français et en droit québécois." *Revue générale de droit* 18 (1987): 421-43.
- Pressman, S. "The Baby Brokers." *California Lawyer* 11 (July 1991): 30-34, 105.
- Quebec. Comité de travail sur les nouvelles technologies de reproduction humaine. *Rapport*. Quebec: Ministère de la Santé et des Services sociaux, 1988.
- Quebec. Conseil du statut de la femme. *General Opinion of the Conseil du statut de la femme in Regard to New Reproductive Technologies*. Quebec: Conseil du statut de la femme, 1989.
- Radke, S.A. "Law, Liberty and Childbearing at the Turn of the Century: Maternal Liability, Surrogate Motherhood, and Donated Genetic Material." Calgary: Alberta Civil Liberties Research Centre, 1990.

- Raymond, J.G. "The Spermatic Market: Surrogate Stock and Liquid Assets." *Reproductive and Genetic Engineering* 1 (1988): 65-75.
- "Reproductive Technology and the Procreation Rights of the Unmarried." *Harvard Law Review* 98 (1984-85): 669-85.
- Roberge, D. "Normes de pratique professionnelle: renseignements dénominalisés et retrouvailles dans le contexte de l'adoption." Montreal: Centre de Services sociaux du Montréal métropolitain, 1991.
- Robertson, J.A. "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction." *Southern California Law Review* 59 (1986): 939-1041.
- . "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction." *Law, Medicine and Health Care* 16 (1988): 18-26.
- Rothman, B.K. *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. New York: W.W. Norton, 1989.
- Rothstein, J. "Surrogacy Contracts: Blending Family Law with Contract Law." *American Journal of Family Law* 5 (1991): 57-68.
- Rousseau, F. "Nouvelles technologies de la reproduction: questions soulevées dans la littérature générale." Quebec: Conseil du statut de la femme, 1985.
- "Rumpelstiltskin Revisited: The Inalienable Rights of Surrogate Mothers." *Harvard Law Review* 99 (1985-86): 1936-55.
- Russell, I.S. "Within the Best Interests of the Child: The Factor of Parental Status in Custody Disputes Arising from Surrogacy Contracts." *Journal of Family Law* 27 (1988-89): 585-671.
- Ryan, M.A. "The Argument for Unlimited Procreative Liberty: A Feminist Critique." *Hastings Center Report* 20 (July-August 1990): 6-12.
- Ryder, B. "Equality Rights and Sexual Orientation: Confronting Heterosexual Family Privilege." *Canadian Journal of Family Law* 9 (1990-91): 39-97.
- Salisbury, D.E. "The Use of Blood Test Evidence in Paternity Suits: A Scientific and Legal Analysis." *Faculty of Law Review* 30 (1972): 47-74.
- Sappideen, C. "Life After Death — Sperm Banks, Wills and Perpetuities." *Australian Law Journal* 53 (1979): 311-19.
- Schneider, C.E. "Surrogate Motherhood from the Perspective of Family Law." *Harvard Journal of Law and Public Policy* 13 (1990): 125-31.
- Schuck, P.H. "The Social Utility of Surrogacy." *Harvard Journal of Law and Public Policy* 13 (1990): 132-38.
- Scott, R. "Test Tube Babies, Experimental Medicine and Allied Problems." *Australian Law Journal* 58 (1984): 405-16.
- Shaman, J.M. "Legal Aspects of Artificial Insemination." *Journal of Family Law* 18 (1979-80): 331-51.
- Shapiro, E.D., and L. Schultz. "Single-Sex Families: The Impact of Birth Innovations upon Traditional Family Notions." *Journal of Family Law* 24 (1985-86): 271-81.

- Shultz, M.M. "Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality." *Wisconsin Law Review* 2 (1990): 297-398.
- Silva-Ruiz, P.F. "Artificial Reproduction Techniques, Fertility Regulation: The Challenge of Contemporary Family Law." *American Journal of Comparative Law* 34 (1986): 125-40.
- Singer, P., and D. Wells. *The Reproductive Revolution*. New York: Oxford University Press, 1984.
- Smith, G.D. "Succession Problems Arising from Artificial Insemination, Surrogate Motherhood and Test Tube Babies: A Proposed Solution." *Juvenile and Family Court Journal* 40 (1989): 15-20.
- Smith, G.P., II. "Assisted Noncoital Reproduction: A Comparative Analysis." *Boston University International Law Journal* 8 (1990): 21-52.
- . "Australia's Frozen 'Orphan' Embryos: A Medical, Legal and Ethical Dilemma." *Journal of Family Law* 24 (1985-86): 27-41.
- Smith, G.P., II and R. Iraola. "Sexuality, Privacy and the New Biology." *Marquette Law Review* 67 (1983-84): 263-91.
- Spooner, G.R. "Fathering." *Canadian Family Physician* 34 (1988): 1755-57.
- Stepan, J., ed. *International Survey of Laws on Assisted Procreation*. Zurich: Schulthess Polygraphischer Verlag, 1990.
- Stolcke, V. "New Reproductive Technologies: The Old Quest for Fatherhood." *Reproductive and Genetic Engineering* 1 (1988): 5-19.
- Strong, C., and J.S. Schinfeld. "The Single Woman and Artificial Insemination by Donor." *Journal of Reproductive Medicine* 29 (1984): 293-99.
- Stumpf, A.E. "Redefining Mother: A Legal Matrix for New Reproductive Technologies." *Yale Law Journal* 96 (1986): 187-208.
- Sublett, M.F. "Frozen Embryos: What Are They and How Should the Law Treat Them." *Cleveland State Law Review* 38 (1990): 585-616.
- Sullivan, L. "Social Legislation for the Reproductive Technologies." *Australian Journal of Social Issues* 24 (February 1989): 33-43.
- "Symposium on Reproductive Rights." *Nova Law Review* 13 (Spring 1989).
- Teichman, J. *Illegitimacy: An Examination of Bastardy*. Ithaca: Cornell University Press, 1982.
- . *The Meaning of Illegitimacy*. Cambridge: Englehardt Books, 1978.
- Thorne, B., ed. *Rethinking the Family: Some Feminist Questions*. New York: Longman, 1982.
- Townsend, M.D. "Surrogate Mother Agreements: Contemporary Legal Aspects of a Biblical Notion." *University of Richmond Law Review* 16 (1982): 467-83.
- University of Alberta. Institute of Law Research and Reform. "Status of Children." Report No. 20. Edmonton: 1976.
- Vandelac, L. "Mothergate: Surrogate Mothers, Linguistics, and Androcentric Engineering." In *Gender and Society: Creating a Canadian Women's Sociology*, ed. A.T. McLaren. Toronto: Copp Clark Pitman, 1988.

- Vanier Institute of the Family. "A Family Perspective on the New Reproductive Technologies." Submission to the Royal Commission on New Reproductive Technologies, Ottawa, 1990.
- Vevers, J.E. "The Social Meanings of Parenthood." *Psychiatry* 36 (1973): 291-310.
- Vogel, P. "The Right to Parent." *Entourage* 2 (Winter 1987): 33-39.
- Wadlington, W. "Artificial Conception: The Challenge for Family Law." *Virginia Law Review* 69 (1983): 465-519.
- . "The United States: Continuing Reform to Reflect Social and Economic Realities." *Journal of Family Law* 26 (1987-88): 237-46.
- Wagner, W.J. "The Contractual Reallocation of Procreative Resources and Parental Rights: The Natural Endowment Critique." *Case Western Reserve Law Review* 41 (1990-91): 1-202.
- . "The Ethical and Legal Implications of Hired Maternity." *American Journal of Jurisprudence* 35 (1990): 187-216.
- Waller, L. "Borne for Another." *Monash University Law Review* 10 (1984): 113-30.
- Weber, W.M. "The Personhood of Unborn Children: A First Principle in 'Surrogate Motherhood' Analysis." *Harvard Journal of Law and Public Policy* 13 (1990): 150-57.
- Wikler, N.J. "Society's Response to the New Reproductive Technologies: The Feminist Perspectives." *Southern California Law Review* 59 (1985-86): 1043-57.
- Williams, J.F. "Differential Treatment of Men and Women by Artificial Reproduction Statutes." *Tulsa Law Journal* 21 (1986): 463-84.
- Williams, L.S. "But What Will They Mean for Women? Feminist Concerns About the New Reproductive Technologies." Ottawa: Canadian Research Institute for the Advancement of Women, 1986.
- Woliver, L.R. "Reproductive Technologies and Surrogacy: Policy Concerns for Women." *Politics and the Life Sciences* 8 (1990): 185-93.
- Wright, M. "Surrogacy and Adoption: Problems and Possibilities." *Family Law* 16 (1986): 109-13.
- Yoon, M. "The Uniform Status of Children of Assisted Conception Act: Does It Protect the Best Interests of the Child in a Surrogate Arrangement?" *American Journal of Law and Medicine* 16 (1990): 525-53.
- Zipper, J. "What Else Is New? Reproductive Technologies and Custody Politics." In *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen. London: Routledge, 1989.

Cases

Anderson v. Luoma (1986) 50 R.F.L. (2d) 127.

Anna J. v. Mark C., Calif. Ct. App. 4th Dist., No. G010255, 8 October 1991.

Atkinson v. Atkinson 160 Mich. App. 601, 408 N.W. 2d 516 (1987).

Bedard v. Bedard (1984) [1985], 43 R.F.L. (2d) 331 (Man. C.A.).

- C.(G.) v. V.-F.(T.)*, [1987] 2 S.C.R. 244.
- C.M. v. C.C.* 377 A.2d 821 (1977 N.J. Sup. Ct.).
- Canada (A.G.) v. Mossop*, S.C.C. 25 February 1993 (unreported) case no. 22145.
- Canada (A.G.) v. Mossop*, [1991] 1 F.C. 18 (C.A.) (leave granted 25 January 1991, SCC Bulletin, p. 157, No. 23145).
- Cardinal v. Cardinal* (1988), 62 Alta. L.R. (2d) 66 (Q.B.).
- Carney v. Diana*, No. 89,191,039-CE 99,949 (Baltimore City Cir. Ct., 11 January 1990).
- Clapp v. Morin* (1991), 82 D.L.R. (4th) 353 (O.C.).
- Crocker v. Sipus* (1992), 41 R.F.L. (3d) 5.
- Csicsiri v. Csicsiri* (1974) [1975], 17 R.F.L. 32 (Alta. S.C.).
- Cyrenne v. Moar* (1986), 2 R.F.L. (3d) 414 (Man. C.A.).
- Douglas v. The Queen*, 1 December 1992, (FCA) Court File No.: T-160-90.
- Draunevicius v. Wilson* (1990), 25 R.F.L. (3d) 85 (Man. Q.B.); appeal dismissed (1991), 30 R.F.L. (3d) 267 (Man. C.A.).
- Droits de la famille* 526, [1988] RLQ 1966 (C.A.).
- Fishburne v. Eggleton* (1987) [1988], 12 R.F.L. (3d) 251 (B.C.S.C.).
- Gordon et al. v. Gordon* (1975) [1976], 20 R.F.L. 355 (Ont.).
- Gursky v. Gursky* 39 Misc. 2d 1083, 242 N.Y.S. 2d 406 (Sup. Ct. 1963).
- H.(F.V.) v. O.(D.A.)* (1988) 16 R.F.L. 430 (N.B.C.A.).
- Hatg v. Canada* (1992), 9 O.R. (3d) 495 (Ont. C.A.).
- Hardcastle v. Huculak* (1987) [1988], 11 R.F.L. (3d) 363 (Sask. C.A.).
- Hepton v. Maat*, [1957] S.C.R. 606.
- In the Matter of Baby M*, 217 N.J. Super. 313, 537 A.2d 1128 [1987].
- Jhordan C. v. Mary K.*, 224 Cal. Rptr. 530 (1986 Cal. Ct. App.).
- Johnson v. Calvert*.
- Kastning v. Charles et al.* (1987), 80 A.R. 150 (Q.B.).
- King v. Low*, [1985] 1 S.C.R. 87.
- King v. Ward* (1984), 41 R.F.L. (2d) 98 (Ont. Prov. Ct.).
- Kristoff v. Kristoff* (1987), 59 O.R. (2d) 464 (D.C.).
- Lapp v. Dupuis* (1985), 45 R.F.L. (2d) 23 (Man. C.A.).
- M. (C.G.) v. W. (C.)* (1990), 23 R.F.L. (3d) 1.
- M. (T.L.) v. F. (G.E.)* (1988), 60 Alta. L.R. (2d) 65 (C.A.).
- McGee v. Waldern and Cunningham*, [1971] 4 W.W.R. 684 (Alta. S.C.).
- McKay v. Sambles* (1992), 36 R.F.L. (3d) 383 (N.B.C.Q.B.).
- Milne v. Milne* (1985), 44 R.F.L. (2d) 241 (B.C.C.A.).
- Moores v. Feldstein*, [1973] 3 O.R. 921 (C.A.).

- New Brunswick (Minster of Health and Community Services) v. C.(G.C.), [1988] 1 S.C.R. 1073.*
- Patton v. Patton* (1978), 1 F.L.R.A.C. 212 (Ont. Co. Ct.).
- Patton v. Patton* (1982), 27 R.F.L. (2d) 202 (N.S.S.C.).
- Pike v. Pike* (1984), 38 R.F.L. (2d) 71 (Ont. H.C.).
- Re Agar; McNeilly v. Agar*, [1958] S.C.R. 52 ("the trilogy").
- Re Baby Duffell; Martin v. Duffell*, [1950] S.C.R. 737.
- Re Fitzpatrick* (1986), 57 Nfld. & P.E.I.R. 38 (Nfld. S.C.).
- Re L.G.A.B.* (1989), 101 A.R. 92 (Prov. Ct.).
- Re Pamela A.* (1969) [1970], 1 N.S.R. (2d) 232 (S.C.).
- Rosta v. Thiel* (1986), 72 N.S.R. (2d) 33 (S.C.).
- Sabol v. Bowling*, No. CF-27,024 (Cal. Super. Ct., Los Angeles Cty., 30 January 1989).
- Scott v. Hotchkiss* (1990), 26 R.F.L. (3d) 26 (Alta. Prov. Ct.).
- Shtitz v. C.N.R.*, [1927] 1 D.L.R. 959 (Sask. C.A.).
- Smith v. Jones*, No. 85532014 DZ (Michigan Cir. Ct., Wayne County, 4 March, 1986).
- Theriault v. Dettaire* (1992), 117 N.B.R. (2d) 402.
- Twaddle v. Twaddle* (1985), 46 R.F.L. (2d) 337 (N.S.S.C.).
- Walker v. Smith* (1987), 56 Alta. L.R. (2d) 285 (Q.B.).
- Wener v. Wener* 35 A.D. 2d 50, 312 N.Y.S. 2d 815 (1970).
- Wiltshire v. Wiltshire* (1975), 20 R.F.L. 50 (Ont. H.C.).

Statutes

- Alberta. Child Welfare Act, S.A. 1984, c. C-8.1.
—. Domestic Relations Act, R.S.A. 1980, c. D-37.
—. Maintenance and Recovery Act, R.S.A. 1980, c. M-2.
—. Maintenance Order Act, R.S.A. 1980, c. M-1.
—. Parentage and Maintenance Act, S.A. 1990, c. P-0.7.
—. Provincial Court Act, R.S.A. 1980, c. P-20.
—. Vital Statistics Act, R.S.A. 1980, c. V-4.
- Australia. South Australia. Family Relations Act Amendment Act, 1984.
- Australia. Victoria. Status of Children (Amendment Act, 1984, Principal Act No. 8602 as amended by No. 9863).
- British Columbia. Adoption Act, R.S.B.C. 1979, c. 4.
—. Adoption Act, S.B.C. 1990, c. 30.
—. Family Relations Act, R.S.B.C. 1979, c. 121.
—. Law and Equity Act, R.S.B.C. 1979, c. 224.

—. Vital Statistics Act, R.S.B.C. 1979, c. 425.

—. Vital Statistics Amendment Act, 1987, S.B.C. 1987, c. 32.

Canada. *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

—. Canadian Human Rights Act, R.S.C. 1985, c. H-6.

—. Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

—. Criminal Code, R.S.C. 1985, c. C-46.

—. Divorce Act, 1985, S.C. 1986, c. 4.

—. Divorce Act, R.S.C. 1985 (2nd Supp.), c. 3.

Canada. House of Commons. Thirty-Fourth Parliament, Third Session. Bill C-108, An Act to Amend the Canadian Human Rights Act and other Acts in consequence thereof. First Reading, 10 December 1992.

Manitoba. The Child and Family Services Act, S.M. 1985-86, c. 8.

—. The Family Maintenance Act, R.S.M. 1987, c. F-20.

—. The Vital Statistics Act, R.S.M. 1987, c. V60.

New Brunswick. Family Services Act, S.N.B. 1980, c. F-2.2.

—. Guardianship of Children Act, R.S.N.B. 1973, c. G-8.

—. Vital Statistics Act, S.N.B. 1979, c. V-3.

Newfoundland. Adoption of Children Act, R.S.Nfld. 1990, c. A-3.

—. Children of Unmarried Parents Act, R.S.Nfld. 1970, c. 38.

—. Children's Law Act, R.S.Nfld. 1990, c. C-13.

—. Family Law Act, R.S.Nfld. 1990, c. F-2.

—. Vital Statistics Act, R.S.Nfld. 1990, c. V-6.

Northwest Territories. Child Welfare Act, R.S.N.W.T. 1988, c. C-6.

—. Domestic Relations Act, R.S.N.W.T. 1988, c. D-8.

—. Maintenance Act, R.S.N.W.T. 1988, c. M-1.

—. Vital Statistics Act, R.S.N.W.T. 1988, c. V-3.

Nova Scotia. Children and Family Services Act, S.N.S. 1990, c. 5.

—. Children's Services Act, R.S.N.S. 1989, c. 68.

—. Family Maintenance Act, R.S.N.S. 1989, c. 160.

—. Infant's Custody Act, R.S.N.S. 1989, c. 228.

—. Vital Statistics Act, R.S.N.S. 1989, c. 494.

Ontario. Child and Family Services Act, R.S.O. 1990, c. C.11.

—. Children's Law Reform Act, R.S.O. 1990, c. C.12.

—. Family Law Act, R.S.O. 1990, c. F.3.

—. Vital Statistics Act, R.S.O. 1990, c. V.4.

Prince Edward Island. Adoption Act, R.S.P.E.I. 1988, c. A-4.

- . Child Status Act, R.S.P.E.I. 1988, c. C-6.
- . Custody Jurisdiction and Enforcement Act, R.S.P.E.I. 1988, c. C-33.
- . Family Law Reform Act, R.S.P.E.I. 1988, c. F-3.
- . Vital Statistics Act, R.S.P.E.I. 1988, c. V-4.

Quebec. Act to Provide for the Carrying Out of the Family Law Reform and to Amend the Code of Civil Procedure, S.Q. 1982, c. 17.

- . Civil Code of Lower Canada (C.C.L.C.).
- . Civil Code of Quebec (C.C.Q.), S.Q. 1991, c. 64.
- . Youth Protection Act, S.Q. 1977, c. 20.

Saskatchewan. The Adoption Act, S.S. 1989-90, c. A-5.1.

- . The Children of Unmarried Parents Act, R.S.S. 1978, c. C-8.
- . The Children's Law Act, S.S. 1990-91, c. C-8.1.
- . The Family Maintenance Act, S.S. 1990-91, c. F-6.1.
- . The Vital Statistics Act, R.S.S. 1978, c. V-7.

Yukon. Children's Act, R.S.Y. 1986, c. 22.

- . Family Property and Support Act, R.S.Y. 1986, c. 63.
- . Vital Statistics Act, R.S.Y. 1986, c. 175.



“Surrogate Motherhood”: Legal and Ethical Analysis

Juliet R. Guichon



Executive Summary

Introduction

This report aims to assist the Royal Commission on New Reproductive Technologies to develop legislative policy regarding the practice of preconception arrangements, commonly but inaccurately known as “surrogate motherhood.” The premise of this study is that conclusions ought to be based on the most accurate and complete description available of the practice and its effects.

A significant finding of this report is that there is little descriptive research about the actual practice of preconception arrangements conducted by persons who do not profit directly or indirectly from them. Moreover, there are no long-term studies about the effects of the practice. For these reasons, this report recommends that serious research be undertaken by social scientists to yield demographic data about the parties and data concerning the long-term outcomes of the practice for the full range of persons potentially affected by a preconception arrangement. (These include the carrying woman; the commissioned child; the carrying woman's other children, her partner,

and her parents; the commissioning woman; the commissioning woman's other children and her parents; the commissioning man; the commissioning man's other children and his parents.)

Despite the lack of comprehensive social science research, there is an abundance of first-hand accounts of the practice, particularly by carrying women. Because these accounts have not been elicited in a systematic way, the opinions and sentiments they express might not be representative of participants whose experiences are not public. Nonetheless, the accounts are a rich source of information regarding how the practice has affected real people.

Prior to this study, these accounts had not been the subject of rigorous analysis. The present analysis reveals four matters of central significance for policy makers:

1. Both the public in general and most commentators have an incomplete and misleading view of the practice of preconception arrangements;
2. The practice in its standard form (that is, where conception is initiated by donor insemination) is of unambiguous benefit only to the commissioning man and to the broker (and perhaps also to the commissioning man's parents);
3. The practice (particularly in its newest form where the carrying woman gestates an embryo created from the commissioners' gametes and gives birth) is improperly described as medical treatment, for it does not aim to cure or alleviate the medical symptoms of infertility, nor is it conducted (primarily) on an ill person but rather on a healthy third party; and
4. In discounting the vital relationship between a child and its birth mother and between the child and the other members of the birth mother's family, the practice of preconception arrangements attempts to transform procreation into production. In so doing, it aims to maximize gain rather than to minimize disaster, and threatens to alter how society values children, pregnancy, and childbirth, as well as the central role of women in human procreation.

Summary of Report

Part 1 defines the practice, gives estimates of its incidence in Canada, the United Kingdom, the United States, and Australia, and describes the nature of the agreement between the commissioner and the broker. It concludes by presenting the available comparative demographic data on the participants, which indicate that carrying women tend to be much younger, less well educated, and less affluent than the commissioners.

Part 2 describes the terms of a preconception agreement and examines whether such an agreement would be enforceable at the instance of the commissioning man under Ontario law. Ontario

legislation does not deal directly with the issue, nor has any such case been litigated in Canada. Nevertheless, it is reasonable to conclude that a dispute arising from a preconception agreement would be decided not by a contract law test of giving effect to the adults' intentions, but according to family law principles concerned with the commissioned child's best interests. The agreement itself would probably not be enforceable. Whether it *ought* to be enforceable in Canada is the question to which the remainder of the report is addressed.

Part 3 considers the "factual" assumptions on which proponents of preconception arrangements generally base their arguments, and suggests that these assumptions are inaccurate. In describing as completely as possible the full range of demand and supply in preconception arrangements, this analysis reveals that the range of commissioners and their desires is much broader than commonly depicted. Moreover, the common but inaccurate depiction generates the participation of, and favourably characterizes, prospective carrying women. Independently of this inaccurate depiction of the range of commissioners and their desires, carrying women, as a group, cannot accurately be described as freely agreeing before conception to relinquish their children forever. Such a portrayal might be adequate to describe the perspective of a semen "donor" but is insufficiently complex to explain the range of motivations in the vastly different situation where a woman agrees to participate as a carrying woman in a preconception arrangement. Such a course of action might not be chosen; it might be taken in a financially or psychologically problematic context that constrains decision making; it is often perceived by carrying women to be different from the decision actually to relinquish the commissioned child; and it does not necessarily entail that the woman wishes to sever forever her relationship with the child. Not only is the common depiction inaccurate with respect to demand and supply, but it does not account for the significant interests of brokers in perpetuating the misleading picture of the practice and the considerable interests of both brokers and infertility practitioners in benefitting from the practice financially and otherwise. Further, the common picture fails to take sufficient account of the actual and potentially harmful effects of the practice on the six classes of persons affected thereby: the carrying woman; the commissioned child; the carrying woman's other children, her partner, and her parents; and the commissioning woman. These effects are described in detail in this part.

In Part 4 the report addresses the principal arguments in favour of the practice. These arguments are based on rights, medical necessity, liberty, and freedom of contract. The arguments are shown to proceed from an incomplete and misleading picture of the practice and to be internally inconsistent. Of even greater significance is that they share the premise that the agreements concern market production, which is a wholly inadequate model for understanding the practice.

A better approach — from a growth perspective — is advocated in Part 5. Such a developmental approach would recognize that preconception arrangements are not about manufacturing products but concern the conception, gestation, and birth of children. In the process

of bringing a child into the world, a woman and her family usually develop a significant relationship with the child. Although there are insufficient data to be certain, to the extent that these relationships develop, they will likely develop irrespective of the origin of the ovum. Whereas a production model completely discounts the process of conception, pregnancy, childbirth, and lactation, a growth perspective not only recognizes the process, but also respects its power to change the lives of those involved in procreation. Whereas a market production model is the basis of contract law, a growth perspective is adopted by family law, which, it is argued, is therefore the most appropriate branch of law to govern the practice of preconception arrangements. Based on existing family law and principles derived therefrom, Part 5 proposes legislation in the form of 10 specific recommendations that would seek to discourage the practice by, among other things, explicitly banning commercial and paid arrangements.

To situate this proposal in the context of other common law jurisdictions, Part 6 describes legislation and law reform proposals in the United Kingdom, Australia, and the United States. This discussion reveals that the proposal is consistent with the general legislative trend that, for the most part, seeks to discourage the practice with prohibitory legislation. For example, in the United Kingdom, the three Australian states (Queensland, South Australia, and Victoria), and 10 of the 12 U.S. states that have legislated directly on the matter (Arizona, Indiana, Kentucky, Louisiana, Michigan, Nebraska, New York, North Dakota, Utah, and Washington), preconception agreements are void and unenforceable. The United Kingdom, the three Australian states, and seven U.S. states (Arizona, Florida, Kentucky, Michigan, New York, Utah, and Washington) make illegal the involvement of brokers who profit from the practice. Further, it is illegal in Queensland and Victoria, and in the seven U.S. states that also ban brokers, for a carrying woman to be offered or to accept payment to relinquish her child. By contrast, formal consideration of the practice in Canada is divided in result. No Canadian province other than Quebec has passed legislation concerning preconception arrangements. Whereas legislation in Quebec and the Law Reform Commission of Canada recommendations are in step with the general legislative trend (by legislating that the agreements remain void and by advocating the same and that the activity of brokers be criminally illegal), the Ontario Law Reform Commission (OLRC) not only would permit paid arrangements under judicial supervision, but recommends the forceable separation and permanent removal of a child from its birth mother should she wish to renounce the agreement and rear the child.

Parts 7 and 8 consider whether there is any legal impediment presented by either international law or Canadian constitutional law to the enactment of legislation to ban commercial and paid preconception arrangements. Part 7 concludes that Canadians do not have a right recognized by international law that would prevent state prohibition of commercial and paid preconception arrangements. On the contrary, Canada has assumed international legal obligations requiring it to promote the best interests of children by, among other things, ensuring

that children are reared by their parents whenever possible and that they do not become the subject of commerce or exploitation.

Part 8 concludes that legislation banning commercial and paid arrangements would probably not be impeded by the Charter. Such legislation would be much like existing law governing custody agreements and adoption. Its purpose similarly would be not to deny commissioners the right to procreate but to limit the means by which they may legitimately alleviate their suffering in order to protect two vulnerable groups: prospective carrying women, and children.

Appendix 1 discusses whether the U.S. Supreme Court privacy cases recognize a right to participate in a preconception arrangement, and concludes that they do not. Appendix 2 analyzes and criticizes the OLRC's arguments and recommendations concerning preconception arrangements.

Conclusion and Summary of Recommendations

In summary, this report demonstrates that the practice of preconception arrangements is designed primarily to satisfy the desires of commissioners, brokers, and infertility practitioners. The available evidence indicates that it has had and continues to have the potential for significant long-term negative effects on a number of persons affected by it, most notably the birth mother and her family. Until rigorous, disinterested social science research is conducted that refutes these preliminary findings, legislative policy ought to discourage the practice. For this reason, it is recommended that

1. commercial and paid preconception arrangements and any advertising connected with the practice be legally prohibited;
2. all preconception arrangements be declared void and unenforceable;
3. the woman who gives birth to a child be considered the mother of the child for all legal purposes and, as such, may relinquish her maternal rights and responsibilities by surrendering or consenting to the adoption of her child only after giving birth and in accordance with provincial adoption law governing relinquishment;
4. in the event of a custody dispute, the birth mother of a child born pursuant to a preconception arrangement be entitled to retain sole custody of the child unless, based on clear and compelling evidence, it can be demonstrated that it is not in the child's best interests to be reared by her; and
5. the ordinary rules of family law with respect to paternity determination, access, and support be declared specifically applicable to cases where children are born as a consequence of a preconception arrangement.

A Note on Terminology

The practice and the participants in the practice that is the subject of this report are usually described in a manner that impedes inquiry. The practice is popularly known as "surrogate motherhood," which inaccurately suggests that birth mothers are substitutes and not real mothers. The persons who seek to gain custody of children by means of this practice are variously called "the fathers," "the social parents," "the adopting parents," and "the parental couples"; these are each problematic descriptions because they beg the question as to who are, and who ought actually to be considered, the parents of the children commissioned prior to conception. A third difficulty with terminology in this field is that the arrangements and agreements that participants make are called "contracts." This term assumes the very question at issue in legal and ethical analysis, *viz.*: whether the arrangements and agreements are, or ought to be, legally enforceable.

The terminology adopted in this report is chosen to avoid the problems to which the more popular terminology gives rise. To leave open the question of who ought to be considered a commissioned child's mother and father, the report describes the adult participants with reference to the principal role each plays in the arrangement made before the child's conception. The woman who bears the child is called the "carrying woman." When the origin of the ovum is relevant, she is more particularly described as a "genetic-gestational woman" (when the ovum is of her body), or an "exclusively gestational woman" (when the ovum originated in the body of another). The person or persons who made the arrangement with the carrying woman are called "commissioner(s)." To leave open the question of whether the arrangements are or ought to be legally enforceable, the practice itself is described as a "preconception arrangement" — that is, the social practice of arranging before the conception of a child for its conception and transfer after birth from the carrying woman to the commissioner(s). When a particular preconception arrangement takes written form, that document is referred to as a "preconception agreement."

These terms, chosen in preference to their more popular counterparts, might be thought stylistically cumbersome, and reductionist in (among other ways) describing participants by their function in the arrangement rather than by their hopes, which the arrangement is meant to fulfil. While acknowledging these potential criticisms, this report nevertheless uses the less popular terms in an effort to add clarity to the debate.

Part 1. Preconception Agreements: An Introduction to the Practice and Participants

Definition

A preconception agreement is an arrangement whereby a woman agrees to gestate and give birth to a child for the purpose of surrendering that child immediately to another person or persons. At the heart of the agreement are the central promises of the parties. The woman promises to become pregnant either by a manual or scientific procedure using the commissioning man's sperm or, much less commonly, by having sexual intercourse with the commissioning man. Further, she agrees to surrender custody of the child irrevocably upon birth. The man (and his partner, if any) promises to accept the child.¹

Generally speaking, the purpose of such an arrangement is to permit a heterosexual couple to raise a child genetically related to the man in cases where his partner is unable to become pregnant and to deliver a healthy child. Much less commonly, the arrangement is made by a single man² or woman, or a homosexual couple.

For the purpose of analyzing preconception agreements, it is helpful to characterize them by the origin of the female gametes, by whether the carrying woman is paid, and by whether there are any intermediaries.

Characterization by the Origin of the Ovum

The ovum that becomes fertilized and gestated can originate from the woman who carries and delivers the child, from the female partner of the commissioning man, or from a third woman.

In most arrangements, the ovum is that of the gestating woman. A preconception agreement usually involves the artificial insemination of the carrying woman using the commissioning man's sperm. The same result can be achieved by sexual intercourse, which is sometimes the means of conception. By either means, the resulting child is genetically and gestationally related to the woman who delivers it and who has agreed to surrender custody to the man. This form of agreement is referred to as a "genetic-gestational preconception arrangement."

A second form of arrangement is "exclusively gestational." In this arrangement, the ovum originates either from the woman who hopes to raise the child or from a third woman. We refer to the woman from whom the ovum originated as the "genetic woman." The "gestational woman," who carries and gives birth to the child, is not genetically related to the child.

There are two techniques to initiate an exclusively gestational pregnancy. By the first, physicians extract the genetic woman's ovum for fertilization in a petri dish; the resulting embryo is transplanted into the uterus of the gestating woman. That woman is expected, under the terms of the arrangement, to surrender the child upon birth to the genetic woman or to a third woman who will rear the child. There is also a second, much

less common technique, which is not viewed as appropriate in Canada because of its dangers. In this technique, the genetic woman's ovum is fertilized in her body by artificial insemination or sexual intercourse, and the embryo is flushed from her by lavage. The embryo is transferred into the gestating woman who surrenders the child when it is born. Each technique has the same result: it divides motherhood so that at least two women and possibly three are involved, a genetic woman (whose ovum is used), a gestational woman (who carries and gives birth to the child), and a social woman (who raises the child).

Characterization by the Presence of Consideration

In addition to characterization by the origin of the ovum, it is also helpful to describe preconception agreements according to whether the woman who carries the child is paid to do so.

In paid agreements, the typical fee for a carrying woman is said to be \$10 000 (U.S.), which may well be a low estimate.³ Some women do not seek a fee, or simply are not paid.⁴ In such cases, the carrying woman might be related to the woman who will raise the child, or they might be friends. In both paid and unpaid arrangements, the carrying woman's expenses will often be covered. Such expenses include the cost of maternity clothes, health care, and lost employment income.

Characterization by Third-Party Involvement

Third parties who bring the principal parties together are called "brokers." A broker acts on behalf of commissioners and recruits potential carrying women. A broker promotes the parties' mutual intention to create a child to be raised by the commissioning man and his partner, if he has one.

In the United States, brokers charge a fee; in the United Kingdom, they operate on a not-for-profit basis.⁵ Those who charge usually earn a substantial sum each time they arrange an agreement: \$11 000 (U.S.) is a typical fee.⁶ As is described more fully below,⁷ such an arrangement is properly called "commercial" because it is a business: the broker solicits commissioners, advertises for carrying women, arranges for insemination and delivery of a child, and arranges for the transfer of the child's custody from the carrying woman to the commissioners. Where a broker participates in a preconception arrangement for profit, the arrangement is called a "commercial arrangement" irrespective of whether the carrying woman is herself paid.

Not-for-profit organizations that facilitate preconception agreements are not common,⁸ but their creation by governments has been suggested by law reform commission members in England⁹ and Australia.¹⁰ Presumably the employees of such undertakings would be paid by the state, from a sum paid by the commissioners, or by money raised through donations.

Preconception arrangements do not necessarily involve intermediaries. The principal parties can come together after placing an advertisement or after hearing indirectly that the other party is interested. For example, in the United Kingdom, where commercial arrangements may not take place,

at least three cases of preconception agreements originated without the intervention of third parties.¹¹

Incidence

The number of preconception agreements cannot be stated accurately. Participants are reluctant to provide concrete information to researchers perhaps because of "fairly unrestrained popular hostility"¹² toward the practice and because of the uncertain legal status of the agreements. If participants do not report their activity, the arrangements are unlikely to come to light because the most typical arrangement (genetic-gestational) can be conducted without attracting public attention. Because the pregnancy is initiated by either sexual intercourse or the technically simple procedure of artificial insemination, it involves a relatively small number of people. Arrangements conducted through commercial agencies involve more people and are revealed more often than private arrangements; they are therefore likely to be over-represented in estimates of the incidence of the practice of preconception agreements.

Canada

A study conducted by Margrit Eichler and Phebe Poole in the summer of 1988 for the Law Reform Commission of Canada estimated there have been at least 118 cases of preconception agreements involving one or more Canadian participants.¹³ Of the 118 cases cited by the study, at least 76 involved an American commercial agency. The remaining 42 cases took place within Canada and were usually reported by people who did not participate in the arrangement; consequently, details of their exact nature are scant.¹⁴

In the cases involving profit-making American agencies, 13 Canadian women either gestated or were in the process of gestating a child to be surrendered; 62 Canadian couples had received or were waiting to receive a child; and one single Canadian man received a child.¹⁵

The operator of what is perhaps the best-known commercial agency is Noel Keane of Dearborn, Michigan. His agency has dealt with a relatively high number of Canadians. Noel Keane opened his files to Eichler and Poole, who reported details of 32 of the 38 cases Keane had brokered involving Canadian participants.¹⁶

Eichler and Poole concluded that, although they had irrefutable proof with regard to the 118 cases, the actual incidence of preconception agreements was almost certainly much higher.¹⁷ Indeed, despite its concentration on Canadian cases, the study's major finding was of international significance: even conservatively estimated, the number of preconception arrangements was much higher than suggested by other experts.¹⁸

The United Kingdom

There is no accurate information about the number of preconception agreements in the United Kingdom. In 1985, the United Kingdom passed

the Surrogacy Arrangements Act 1985,¹⁹ which made it criminally illegal to advertise concerning preconception agreements. The Act prohibits commercial but not paid agreements. Given that it is easier to obtain information about commercial arrangements than about arrangements conducted privately, it is especially difficult to know how many arrangements have been made privately in the United Kingdom since the legislation was passed.

As legal commentator Derek Morgan has noted, determining the incidence of the practice in the United Kingdom is a matter of conjecture and hypothesis.²⁰ From an examination of primary sources (law reports, reports to local social services departments, and academic commentators' reports to social services departments), he concluded there have been 29 cases. From less easily verifiable sources (the correspondence received by carrying women from other potential carrying women or infertile couples), there appeared to be an additional seven cases. Local authorities' social services departments suspected the existence of at least another seven. These three general sources produced a total of 43. "In other words, the cautious observer would state that there have been between 29 definite, 38 probable and 43 possible cases of *known* [preconception] arrangements in the United Kingdom [between 1976 and 1989]."²¹

Since 1989, no doubt the number has grown because of the new practice in English infertility clinics of implanting embryos in what they call "host mothers." In other words, the clinics now participate in making exclusively gestational arrangements.²²

The United States

There has not been a comprehensive study of the incidence of preconception agreements in the United States. Estimates made in the late 1980s indicated that the total number of all preconception arrangements was about 600.²³ Yet the 1990 California report of the Joint Legislative Committee on Surrogate Parenting claimed that the approximate incidence in the United States was much higher. The minority report stated that there had been approximately 250 births arranged commercially in California between 1980 and 1990, and a further 250 conducted privately since 1978. It estimated that 2 000 children had been born in conjunction with commercial operations nationwide since 1975, and that a further 2 000 births had been arranged privately. In this way, the minority report estimated that there have been 4 500 genetic-gestational preconception arrangements resulting in children in the United States in the period 1975-1990.²⁴

The report also noted that the number of exclusively gestational arrangements is "fast on the rise" and may eventually outnumber "traditional" (i.e., genetic-gestational) arrangements. It cited the example of the Center for Surrogate Parenting in Beverly Hills, California, where approximately 50 percent of the clients in 1990 were participating in exclusively gestational arrangements.

Australia

There is no reliable estimate of the number of preconception agreements that have been made in Australia. The New South Wales Law Reform Commission was asked by the Attorney General on 5 October 1983 to inquire into all aspects of artificial conception, including preconception arrangements, but the commission stated that it could not obtain accurate information about the incidence of preconception arrangements in Australia.²⁵

Description of Preconception Agreements

The information available concerning the substance of actual agreements varies: of some agreements, little is known; of others, it is possible to study the written terms. Consider, for example, a private and apparently oral agreement that came to light only because it was the subject of litigation.²⁶ The facts as found by Mr. Justice Comyn illustrate the informality that can characterize these arrangements and the nature of the obligations. In that case, a 32-year-old divorced mother of two children, Mrs. B, was living with a 27-year-old man (Mr. A), but she was unable to have any more children. She and Mr. A wanted to marry but only if Mr. A could have a child of his own.

Eventually, Mr. A and Mrs. B decided to pick a prostitute and offer her virtually their whole life's savings of £3,500 to conceive a child by Mr. A and to carry, give birth to and then deliver over to Mr. A and Mrs. B the born child ... Mrs. B attended at Bow Street magistrates court one day in about June 1976 to pick a suitable prostitute from those parading to pay their regular fines. She chose a woman who in fact declined the offer but who agreed for an agency fee ... to procure somebody who would accept it. Thus Mr. A and Mrs. B became introduced to Miss C who was only 19 ... She accepted the proposals of Mr. A and Mrs. B, which was now for the sum of £3,000, £500 having gone on the agency fee. She accepted the proposals to be impregnated by Mr. A, and having given birth to the child to hand it over. As additional benefits she was during her pregnancy allowed to occupy with a girl-friend a flat owned by Mrs. B and to have her pregnancy needs seen to. This was all carried into effect.²⁷

Although we know of this agreement because it was litigated, there are probably many others, similarly private and verbal, that do not come to public attention. According to one commentator,

Anecdotal evidence is ubiquitous that friends, sisters, cousins and others related in a familial and/or social way to wives in infertile unions act as surrogate mothers through artificial insemination ... within particular ethnic populations in Canada's larger cities, sisters or cousins of wives unable to bear children would be artificially inseminated through the husbands, usually with no medical or nursing aid. They would go to hospital under the wives' names and health insurance numbers and on giving birth, register the wives as the mothers. On leaving the hospital, they would surrender the children to the couples.²⁸

At the other end of the spectrum from private, oral arrangements are the agreements brokered by legal or medical professionals for a fee. Such agreements, made usually between strangers, are in writing and can be lengthy. The written document becomes public either through the course of the broker's business (when, for example, he or she sends such an agreement to a prospective client), through legal or professional journals, or when the agreement becomes the subject of litigation as in the *Baby M* case. About these commercial arrangements, much is known.

Commercial Agreement Among the Commissioning Man, the Carrying Woman, and Male Partner

The availability of written agreements drafted by American commercial agencies makes it possible to analyze them. An example of such an agreement was published in a 1981 legal journal by its author, Katie Brophy, who drafted it for a Kentucky broker and infertility practitioner, Dr. Richard Levin.²⁹ A second agreement was drafted by lawyer Noel Keane and is routinely made available by his office to prospective clients.³⁰

The Parties

In both these documents, the agreement is between the commissioning man on the one hand, and the genetic-gestational woman and her partner on the other. Both documents ostensibly require that the carrying woman be married. In each case, the commissioning man is represented by the attorney who has drafted the document. Brophy's agreement does not mention the carrying woman's counsel. Keane's agreement advises the carrying woman to seek independent counsel to explain "the legal implications and contractual obligations set forth."³¹ The documents appear to be standard form agreements. The enforceability under Ontario law of the terms of these agreements is considered below in Part 2.

Agreement Between Commercial Broker and Commissioning Man

An example of an agreement between the commissioning man and the broker is provided by Noel Keane's "Attorney-Client Agreement," which he made available in October 1988 upon written inquiry about the nature of his services. The agreement contains two exhibits, "Summary of Costs" and "Statement of Charges Incident to the Surrogate Service."³²

The Parties

The parties to the agreement are the commissioning man and the broker, Noel Keane. Although the agreement is entitled "Attorney-Client Agreement," it appears that Keane acts for the commissioning man in more than a legal capacity. It is appropriate to call him a "broker" in addition to a "lawyer" because he provides services such as advertising for prospective carrying women and arranging for their insemination and support groups, and he handles fees payable by the commissioning man for the carrying woman's lawyer, maternity clothing, medical insurance, and so on. Thus, the services he performs clearly go beyond the merely legal.

Obligations of the Parties

The commissioning man agrees to pay Noel Keane "\$11 000 as compensation for legal and administrative services." He also agrees to pay costs and expenses to be itemized periodically and billed to him. He promises to appoint Noel Keane as his escrow agent for the carrying woman's fee.

In addition to these obligations, the commissioning man assumes a number of risks. For example, he assumes the risk that Noel Keane might not be able to guarantee that the commissioning man's name will be placed on the child's birth certificate, or that the carrying woman and her husband's parental rights will be terminated. The commissioning man agrees to accept that Keane "cannot advise him of all the legal problems and implications which may arise incident to this ... procedure, but [the commissioning man] nevertheless assumes all possible legal risks."

For his part, the broker agrees to act as escrow agent for the fee to be paid by the commissioning man to the carrying woman. He promises to advise the commissioning man on the progress of the insemination and pregnancy as reported to him by the attending physician. He also undertakes to advise the commissioning man of applicable law as it relates to matters relevant to the practice of making preconception arrangements. The broker agrees to negotiate and represent the commissioning man's interests in the agreement that he drafts and to negotiate with other prospective carrying women should the first carrying woman not fulfil the agreement.

The agreement also specifies what the broker will not do. The broker expressly refuses to refund any portion of the fee paid to him by the commissioning man irrespective of whether the commissioning man "ever conceives or receives custody of a child" pursuant to the agreement entered into by the commissioning man and the carrying woman, provided that the broker complies with his duties and obligations under his agreement with the commissioning man. Further, the broker refuses to guarantee or warrant that the carrying woman will in fact conceive a child fathered by the commissioning man, or that if a child is conceived it will be a healthy child, "free from all defects." The broker does not guarantee that the carrying woman and her husband will comply with the terms of the agreement that the broker drafts.

Participants in Preconception Arrangements

Carrying Women

Limitations of Data

Statistical information concerning carrying women is scarce. Because there is no central register of births initiated by preconception arrangements, the ability of researchers to undertake a thorough national or international study is limited.³³ Consequently, information about these women is usually anecdotal rather than statistical. The few studies that

have been conducted involve women who contracted to surrender children through a commercial broker. These studies are not exhaustive as they necessarily exclude private arrangements and arrangements under which no money is exchanged.³⁴

The studies are limited in a second way: they tell us very little about exclusively gestational women. Because most preconception arrangements to date entail artificial insemination, which is technically much easier to perform than embryo transfer, most carrying women can be described as "genetic-gestational" as opposed to "exclusively gestational" women. In other words, in most preconception arrangements, a woman's ovum is fertilized after artificial insemination with the commissioning man's semen. Therefore, most of the limited information available concerns the situation where the carrying woman is the child's mother in every sense, though she agreed before conception to relinquish the child. Thus, she is in a position similar to that of a woman who relinquishes her child for adoption, with the difference that she deliberately conceived the child with the intent to relinquish it to a man who is usually the child's genetic father. We have some information about the group of women who participate in genetic-gestational preconception arrangements, and about the group of women who relinquish their children for adoption, but we have no data about women who gestate an embryo to which they have no genetic relationship. It is not known if the pregnancy and delivery experience of such women is significantly different. There are simply no studies of the experience of exclusively gestational women or studies that compare their experience with that of genetic-gestational women.

A third problem with the available data is that in some cases it has been presented by persons who have a financial or expressed interest in promoting the practice. Two compilations of demographic information concerning women who entered into preconception arrangements through commercial brokers in the United States demonstrate the variety of researchers' interests. The first study published was by Philip J. Parker, a proponent of the practice of preconception arrangements,³⁵ who is a Detroit psychiatrist paid to interview numerous prospective carrying women on behalf of commissioners who hire Noel Keane as their broker and lawyer.³⁶ (Parker's first study presented demographic and motivational data on 125 women who applied to be carrying women.³⁷) A second source is the 1988 U.S. Congress, Office of Technology Assessment (OTA) report,³⁸ which summarizes the demographic data compiled by four researchers (Linkins, Hanafin, Parker, and Franks)³⁹ and presents data it obtained from "surrogate mothering agencies," which responded to a questionnaire. Hanafin is on staff at the Center for Surrogate Parenting in Beverly Hills, California.⁴⁰

Thus, these sources of information are limited in being concerned with commercially brokered arrangements with genetic-gestational women and in being compiled by researchers who are not disinterested. The information is subject to two additional flaws: the research subjects might

have incentive to falsify their responses, and each survey incorporates at least some data derived from the same source.

The responses of the research subjects might not be accurately given or reported. For example, Parker's psychiatric practice involves interviewing prospective carrying women whose desire to participate will be fulfilled or not, partly as a result of their responses to Parker's questions. The OTA survey collected data given to it by the agencies, not by the carrying women. Moreover, the agencies from whom the information was derived are interested in furthering the practice of preconception arrangements and therefore might have been tempted to give only what they perceived to be favourable information.

In addition, the sources of the three studies to be considered here are not independent, so some data appear to be over-represented. Parker collaborates with Noel Keane; the women he interviews are referred to him by Keane's Dearborn agency. The OTA's study involved soliciting information from U.S. commercial agencies, one of which was Noel Keane's. The detailed information in a third study, the Eichler and Poole report, commissioned by the Canadian Law Reform Commission (discussed above), came from studying Noel Keane's files.⁴¹ Therefore, all three compilations report, at least in part, his information. It is difficult to know whether the characteristics of the sample of women reported by Keane vary greatly from those of women affiliated with other agencies. The manner in which the data are reported does not permit such a comparison to be made.

By using the available information, even though it is limited in these ways, one can nevertheless gain some indication of the age, marital status, race, educational attainment, income level, and reproductive history of the genetic-gestational women who seek to enter into preconception arrangements.

Results of the Surveys

In Parker's study, the mean age was 25 years, with a range of 19 to 33 years. Eichler and Poole's study appears not to list the women's ages at the time they gave birth but rather their age in 1988, the year in which the study was conducted. The average age was 26.8 years. The OTA, with a sample of 334, gave an average age of 27 years.

The majority of the women surveyed were married. Parker's study reported that 87 percent were married, Eichler and Poole reported 67 percent, and the OTA reported 60 percent.

The predominant religious affiliation among the women was Christian and, in particular, Protestant. In Parker's study, 53 percent were Protestant and 47 percent Catholic. Eichler and Poole's sample of 18 were 61 percent Protestant and 33 percent Catholic. The OTA reported 67 percent Protestant, 28 percent Catholic, 3 percent Jewish, and 2 percent other.

Most of the carrying women were white. All of the women in Parker's study were white. Eichler and Poole do not give information on race. The

OTA reports that 88 percent were white, 2 percent Hispanic, 2 percent Asian, and less than 1 percent Black.

The majority of women either did not finish high school or have only high school education. Parker reports that 20 percent did not complete high school and 53 percent have only high school education. In Eichler and Poole's study, 8 percent did not finish high school and 54 percent have only high school education. In the OTA report these two groups comprised 61 percent of the women. Eichler and Poole state that 16 percent either have a bachelor's degree or have completed college. The OTA reports that 35 percent attended or completed college and that 4 percent have some graduate school education.

Parker does not provide information on income levels and occupation of carrying women and their partners in his study of 125 women. Eichler and Poole apparently did not have access to income levels but report the occupations of the carrying women and their husbands. Many of the women (44 percent) were housewives or unemployed. Their husbands tended to have blue collar jobs (e.g., assembly worker in a factory, bricklayer, carpenter). The OTA reported that 13 percent had household incomes of less than \$15 000 (U.S.), 53 percent between \$15 000 and \$30 000, and 30 percent between \$30 000 and \$50 000. Only 4 percent had combined incomes over \$50 000 per annum.

Two surveys reported the women's past reproductive history. Parker states that 93 percent had had at least one previous pregnancy. The average number of previous live births was 1.9. Twenty-three percent had had a voluntary abortion; 10 percent had relinquished a child for adoption. The OTA reported that 20 percent had had a voluntary abortion or miscarriage, 7 percent had relinquished a child for adoption, 12 percent were themselves adopted, and 7 percent had previously relinquished a child pursuant to a preconception agreement.

Motivations of Carrying Women

Why do women agree to conceive, carry, and deliver a child to surrender it to a couple whom they may never see again (if indeed they ever have)? Again, the paucity of detailed and reliable surveys means that this question cannot be properly answered. Because there has been no comprehensive study of the motivations of these women, the strength of any stated reason in prompting participation is not known.

The only study of the issue was conducted by Philip Parker, who identified and examined three motivations of applicants: the desire and need for money, the desire to be pregnant, and "the perceived advantages of surrendering the baby."⁴² This third factor included both the experience of giving the "gift" of a baby to an infertile couple and of repeating a prior voluntary loss of a fetus or child. In Parker's opinion, the repetition of a loss "appeared to help the [genetic-gestational woman] ... Generally these repetitions have often been an attempt to master in a wilful act what was felt to be less in control originally."⁴³ As Parker is a proponent of

preconception arrangements and also profits from the practice, his study is not disinterested. Its conclusions are analyzed below in "A More Complete Picture of Supply" in Part 3.

Partners of Carrying Women

Little is known of the motivations of the partners of the carrying women for entering into a preconception arrangement. In a number of cases, it is the woman who has suggested the idea, and her partner has agreed. In some cases the husband has been opposed. For example, a carrying woman, Elizabeth Kane, spoke to her husband at length about the arrangement before he agreed to enter the arrangement with her.⁴⁴ A second woman, Patti Foster, similarly reported that her husband was very much opposed to the idea but eventually agreed to support her.⁴⁵

In other cases, the male partner of the carrying woman appears to agree with her that she enter into the arrangement to increase the household income. A man accompanying his girlfriend to Noel Keane's office said,

I'll take care of her when she's pregnant again, but the baby means absolutely nothing. It's like watching someone's car for nine months. We're in it for the money; it's a business. That's the way we look at it.⁴⁶

Commissioners

Commissioners Described

Apart from anecdotal accounts in popular media reports, there is little demographic information concerning the commissioning people. The only published systematic investigation of commissioning people was that conducted by Margrit Eichler and Phebe Poole,⁴⁷ who used data from 32 arrangements made by Noel Keane. These data permit comparisons between commissioning couples and the carrying woman with respect to age, marital status, religious affiliation, educational attainment, and occupations.

Eichler and Poole found that the commissioning man and woman were much older than the carrying woman.

Of the [commissioning men], six are in their fifties (the oldest is 59), ten are in their forties, and eight are in their mid- to late thirties. [Commissioning women] are a bit younger ... Of the [commissioning women], three are in their fifties, seven are in their forties, and 11 are in their thirties.⁴⁸

The carrying women were significantly younger: four were in their early 30s and the rest were in their 20s. The youngest was only 21 years of age.⁴⁹

To put these two sets of ages into comparative perspective, the youngest commissioning man (age 35) and the youngest commissioning woman (age 34) were older than the oldest carrying woman (age 33). The average age of the carrying women, for whom information was available, was 26.8 years. By contrast, the average age of the commissioning man

was 42.8 years, and the average age of the commissioning woman was 38.5 years.

Whereas most of the commissioners were married, some carrying women were not married at the time of the arrangement. Of the commissioning people, there were 26 couples, one single man, and one about whom there was no information. Of the carrying women, 19 were married, six were single, separated, or divorced, and about three there was no information.⁵⁰

In examining religious affiliation, Eichler and Poole found a concentration of commissioners first in the Jewish faith, second in various Protestant churches, and third in the Catholic Church. By contrast, there were no Jewish carrying women. Carrying women tended to be affiliated with some Protestant church or the Catholic Church. Only one commissioning couple and no carrying women declared themselves agnostic.⁵¹

The investigators stated that it has often been said of carrying women that they are likely to be from lower socioeconomic strata than the commissioning couple.⁵² Their research supports this hypothesis. As a group, the commissioners have a significantly higher level of educational attainment than the carrying women. Data were available on the educational achievements of 17 commissioning men. Two (12 percent) had completed only grade 12, 11 (65 percent) had graduated from college or university, and four (23 percent) had completed graduate school. Of 19 commissioning women, one (5 percent) had less than a complete high school education, two (10 percent) had completed only high school, one (5 percent) had some post-secondary education, ten (53 percent) had completed college or university, and five (26 percent) had completed graduate school (among them two had attained doctoral degrees).⁵³

By contrast, of the 24 carrying women, two (8 percent) did not graduate from high school, 13 (54 percent) had completed grade 12, five (21 percent) had some post-secondary education, four (17 percent) had completed college or university, and none had completed graduate school.⁵⁴ Thus, whereas 88 percent of commissioning men and 79 percent of commissioning women had post-secondary degrees, only 17 percent of carrying women had completed college or university.

With respect to occupation, the sample of commissioners tended to be professionals, whereas the carrying women were "clustered in lower level service occupations and their husbands tend[ed] to be in blue collar or lower level managerial occupations."⁵⁵

The researchers summarized their results by describing a typical commissioning man and woman and typical carrying woman and her partner.

[T]he typical [carrying woman] is young (an average of 26.8 years), has had at least one previous child and often more than one, is more likely married than not, is either a housewife or holds a pink collar job, and when married is married to a blue collar worker or a member of the

lower management. She is more likely to be affiliated with a Catholic or Protestant church than to define herself as without religion.

The typical [commissioning man] is ... older (average age 42.8 years). He is highly likely to be married, is a professional or self employed, and is likely to belong either to the Jewish, Catholic, or some Protestant faith.

The typical [commissioning woman] is somewhat younger than the [commissioning man] but significantly older than the [carrying woman] (average age 38.5 years), is highly likely to be employed, mostly as a professional (but at a lower level profession — such as teacher, business manager or dietician — than her husband, who is more likely to work as an engineer, doctor or lawyer).⁵⁶

Motivations of Commissioners

The common understanding of why commissioners enter into preconception arrangements is that the commissioning woman is unable to conceive or bear a child. There are many reasons why a woman might be unable to conceive and carry a live child to term. She might have some congenital abnormality that disables her, or she might have made or been encouraged to make choices that impaired her fecundity (for example, having contracted a sexually transmitted disease that blocked her fallopian tubes; having been exposed to agents that harm fertility, including workplace hazards; and having agreed to a procedure performed by doctors that accidentally left her sterile).

Whatever the cause, the consequences of impaired fecundity and childlessness can be devastating. The pain of one woman was expressed in the first book of the Bible: "When Rachel saw that she bore Jacob no children, she envied her sister; and she said to Jacob, 'Give me children or I shall die!'"⁵⁷

The desire to have a child should not be underestimated. Human reproduction is an important part of people's existence. In enabling the human race to continue, it brings joy to parents, their relatives and friends, and the community. Children care for their parents in their old age, often having grandchildren who enable the family to continue into another generation. For couples, it can be a devastating experience to learn that their union is not likely to result in a healthy child or children.⁵⁸ For some people, impaired fecundity initiates a crisis affecting their feelings about sexuality, self-image, and self-esteem.⁵⁹ For unmarried and/or homosexual persons, childlessness can also be a painful experience.

Indeed, the loss of the dream of giving birth to and raising (more of) one's own children can be a loss comparable to the loss by death of a loved one. As with death, mourners must go through a series of stages — shock, denial, anger, guilt, depression — to accept the loss and carry on with their own lives.⁶⁰ Although resolution is normally the last stage of grief, it is seldom so with impaired fecundity, which is unlike death in being private, chronic, and unusual.

Impaired fecundity provides no public event around which family and friends can rally with love and support. Because of the problem's private nature, persons are often isolated in their grief, sometimes tormented by the well-intentioned comments of others and by family and child-centred celebrations such as Christmas, Easter, Chanukah, Passover, Mother's Day, and Father's Day.

Nor is impaired fecundity final; it carries on indefinitely like a chronic illness. Each month, there is a reminder of the impairment and hopes for a pregnancy next month. Throughout the months and years of diagnostic tests and fertility treatments, the disturbing emotions do not depart. As one woman wrote, "Infertility is an emotionally devastating disease, which rears its ugly head over and over again. With each month that goes by, the stakes get higher, and the failure is more painful."⁶¹ Sometimes, the relationship between a couple ends as a consequence of impaired fecundity and its associated stress.

Unlike death, impaired fecundity is seen to disrupt the common life cycle. It causes people to lose their link with the past (for example, they will not have a child who resembles its grandmother) and their link with the future. The biological urge to reproduce is, in a sense, the desire to become immortal by having children who will survive oneself.

What we come to love in our children is that they enable us to recapitulate the past of our own growing ... Children also continue our flesh beyond its wearing out, carry us into the future beyond our mortality just as we bear our parents into a future they never live to see. Family love is this dynastic awareness of time, this shared belonging to a chain of generations ... Love for our children is the means by which, to the degree that we ever can, we reconcile ourselves to the last act ... To be mourned as we go is to feel life coming together into a circle of meaning, the love we received from our parents transmitted intact, through our love for each other, to our children, and their love for us whispering in our ears as we slip into darkness.⁶²

The presence of children and their significance as one means by which we survive this life are a comfort denied people who are unable to have children. Rachel's words, taken figuratively, are worth pondering.

Although impaired fecundity is not a new problem, the manner of addressing it has changed in the past generation. In the past, the alternative to child-rearing by natural procreation was adoption. Though adoption does not give the adopters descendants, it does allow them to parent. Yet adoption is not a feasible option for many people today. There are fewer babies available than there were 20 years ago.⁶³ The decline in supply is attributed to the increased effectiveness and use of contraception, the increased availability of abortion, and the greater likelihood of single women keeping their own children rather than surrendering them for adoption.⁶⁴ It would be incorrect, however, to state that preconception arrangements exist only because adoption is not as promising an alternative as it once was. There are important differences.

Preconception arrangements enable the commissioning man (and, in exclusively gestational arrangements, the commissioning woman) to be genetically related to the child. This has significant implications and consequences. From the perspective of the commissioning man, a preconception arrangement enables him to parent his own genetic child.⁶⁵ Indeed, the commercial preconception agreements (introduced above and detailed in Part 2) specifically state that this is the purpose of the arrangement. For some commissioning women, a preconception arrangement is desirable precisely because it enables them to avoid passing deleterious genes to offspring and yet it enables their husbands to have genetically related children.

For commissioners, the practice has further advantages over adoption. By entering into agreements with healthy, middle- to lower-income women whom commissioners often meet in advance, a preconception arrangement enables commissioners to have more control over the prenatal "environment" of the child. The agreement that the parties sign contains a provision prohibiting the carrying woman from smoking, drinking, or taking non-prescription drugs. The commissioners thus might have more power than in adoption to monitor the pregnancy.⁶⁶

Commentators have often expressed concern that a woman might wish to commission a child to avoid the risks and pain of pregnancy and childbirth, and the disruption of her career.⁶⁷ But no such case has ever come to light. On the other hand, there have been at least ten cases of a single man commissioning a child, suggesting that impaired fecundity and genetic disease are not the only motivators of commissioners.⁶⁸

From the perspective of a commissioning couple, exclusively gestational arrangements might be particularly advantageous as they enable a commissioning couple to have a child who is genetically related to both of them. For example, where a commissioning woman does not have a uterus but has functioning ova, an exclusively gestational arrangement permits an embryo created by her egg and her husband's sperm to develop. The embryo is transferred into the body of a carrying woman who, it is intended, will gestate, give birth, and surrender the child at birth.⁶⁹ But in addition to the risks for the carrying woman, this process requires the commissioning woman to undergo pain and discomfort from the invasive procedures to extract her eggs.

To extract the ova for *in vitro* fertilization (IVF), doctors often stimulate women's ovaries artificially to increase the number of ova that are released. Controlled stimulation by hormones makes it more likely than at natural ovulation that several eggs will be extracted, both because the time at which the eggs ripen is more readily known and because the number of eggs released is higher.⁷⁰ This latter reason is important because the chance of pregnancy increases if more than one embryo is implanted.⁷¹ However, hormonal stimulation also creates the risks of pain in the ovaries and mood changes, as well as inconvenience and expense.⁷² Moreover, the long-term effects of the drugs are not known.

Ova are extracted by one of two methods: laparoscopy or transvaginal follicular aspiration. A laparoscope is a device containing optical fibres that allows a physician to see into the abdominal cavity. A surgical technique performed under either general or local anaesthetic, laparoscopy involves egg extraction in which the instrument is inserted through small incisions in the woman's abdominal wall. However, this method is being replaced almost completely by ultrasonically guided transvaginal follicular aspiration, which does not require general anaesthesia, is less time-consuming, and has a low complication rate. Both methods are invasive, involve some risks, and cause, at minimum, discomfort to the woman undergoing the procedures.⁷³

Brokers

Commercial Brokers

From the available information on the subject, it appears that commercial brokers operate only in the United States. Their practices vary and are described more fully in Part 3.⁷⁴ Here we describe what is known of their motives.

The best-known broker is Noel Keane. He arranged the agreement between Mary Beth Whitehead and Bill Stern through his office, the Infertility Center of New York in New York City. In addition to Dearborn and New York City, he also has offices in Indianapolis and in a suburb of San Francisco.⁷⁵

Keane says he made the first preconception arrangement in 1978, between a married man and a single woman.⁷⁶ Keane is the first to have written a book on the subject, *The Surrogate Mother*, published in 1981.⁷⁷ By March of 1987, he had arranged far more surrogate births than anyone else. As a popular magazine noted in 1987,

Since [the first birth in 1978] the baby business has boomed. Keane's surrogate arrangements produced 65 children last year and have delivered 13 already this year, with 31 more on the way. And he has another 150 couples lined up. Each couple pays him a basic fee of \$10 000, as well as \$10 000 to the surrogate when the baby is turned over, plus an average of \$5 000 in medical and other costs.⁷⁸

It appears from popular articles about Keane that he is motivated by money and by the happiness his arrangements bring to his clients, the commissioning couples. "Keane can pay himself '\$120,000 to \$160,000' in salary from the firm's proceeds."⁷⁹ Another press article states,

On Keane's office walls are two framed blow-ups of a magazine cover which asks the question whether Keane is a "baby broker or saint." Naturally enough, he prefers sainthood. Although he makes a "comfortable living" out of it, he claims, "It's not totally business. If I didn't feel good about what I am doing I would get the hell out of it." He has the support of his wife and two sons.⁸⁰

Keane is often criticized not just for arranging preconception arrangements but for the specific manner in which he goes about it. From the perspective of the commissioning couple, Keane is a lawyer who will represent their interests. From the perspective of the carrying woman, he has a "surrogate mothering program" to which they apply in the hopes of being accepted. He attempts to resolve the potential conflict of interest by having the carrying woman represented by a lawyer who, although ostensibly independent of Keane, might be referred to the woman by him.⁸¹

Apart from money and bringing happiness, Keane seems motivated by the attention he gains from the media. "He swishes about in his open Mercedes and seems to measure success by the number of times he appears on television shows."⁸² In reply to criticism by other brokers he has said, "They're just a little jealous. I get the notoriety. I get more volume. I'm smarter." And: 'I'm a big boy. I understand the issues involved.'⁸³

Another broker appears to be similarly motivated, though he claims that his practices are different. Bill Handel, a California lawyer, founded the Center for Surrogate Parenting, Inc. in Beverly Hills, California. This centre apparently "offers the only so-called full-service surrogate program in the country,"⁸⁴ by which he means that commissioners can hire women to participate in genetic-gestational arrangements and exclusively gestational arrangements, and to sell ova to be gestated by commissioning women. The centre claims that a prospective carrying woman "is screened and tested for up to six months before meeting a potential couple. The average applicant — apparently only one in 20 is accepted — spends up to two years in the program before giving birth."⁸⁵

Although his methods are allegedly different, it seems that this centre is also a money-making enterprise. Depending upon the type of arrangement, "the fee ranges from \$20 000 to \$40 000, with the money divided among the doctors, lawyers, counsellors and everyone else who had a hand in the birth."⁸⁶ It is possible that he can charge more than Keane because Handel can state that in none of the 68 births he had arranged by May of 1988 did the carrying woman refuse to give up the child.⁸⁷

Two other notable commercial brokers in the United States are Richard Levin of Louisville, Kentucky, and Betsy Aigen of New York City. Levin is a medical doctor who told a U.S. congressional hearing that he is motivated to meet "the needs of infertile couples," though it is not clear whether he meets the needs of those infertile couples without sufficient funds to pay his fees.⁸⁸ Aigen appears to be motivated by making money and creating happiness for commissioning couples. She founded the Surrogate Mother Program in New York City, after she and her husband entered, as commissioners, into a genetic-gestational arrangement. Aigen, a psychotherapist, and her husband, a psychologist, test the carrying women and make a living from these activities.

Non-Commercial Brokers

As previously stated, it is illegal in the United Kingdom to operate a commercial brokerage firm to arrange preconception arrangements. However, there are two U.K. institutions that facilitate arrangements, but do not charge a brokerage fee.

The first, Childlessness Overcome Through Surrogacy (COTS), is a charity established by Kim Cotton, the first woman known publicly to have entered a preconception arrangement in the United Kingdom, and Gina Dodd, a Scottish-born commissioning woman. COTS "acts as an information and help-line service for people who wish to find a surrogate and who wish to become surrogates."⁸⁹ By operating the service ostensibly without remuneration, Cotton and Dodd appear not to be motivated by the desire to make money. Cotton has said,

I am not trying to promote surrogacy and I am convinced some people shouldn't do it, don't have the emotional strength, don't understand the implications — over the years. I have certainly talked women out of becoming surrogates simply by telling them blow-by-blow what is entailed. But some women can do it, want to do it and it seems to be that it's a wonderful gift to offer a couple who cannot have children. I still feel very very glad I did it.⁹⁰

A second U.K. institution, The Bourn Hall Clinic (in which the world's first IVF conception resulted in a live birth), also facilitates preconception arrangements. In August 1990, the clinic announced that it was prepared to facilitate exclusively gestational arrangements. "Bourn Hall is not the first clinic to implant a frozen embryo into a host mother, but it is the first to discuss the issue openly."⁹¹ The clinic said that it is motivated to facilitate these arrangements by the desire to help certain commissioners. According to Peter Brinsden, the medical director of Bourn Hall, "We believe that patients who are unable to bear children of their own can and should be helped. We will not provide a service for the mother who does not want to interrupt her career by bearing her own child."⁹² He also stressed that couples must make their own arrangements with the carrying woman. The doctors at Bourn Hall said that the clinic's £2 500 (approximately Cdn. \$5 300) fee is only for medical services including counselling for the parties. Nevertheless, the "medical service" provides employment, income, and research opportunities for the clinic staff. By August 1990, the clinic had transferred two embryos into carrying women, in both cases the sisters of the ovum providers.⁹³

Physicians in Australia and South Africa have also facilitated arrangements between commissioning couples and carrying women. In Melbourne⁹⁴ and Perth,⁹⁵ Australia, carrying women gestated the embryos of their sisters and the sisters' husbands. In Johannesburg, South Africa, physicians participated in an IVF conception by which a 48-year-old woman gave birth to two boys and a girl whose genes originated from her daughter and her son-in-law.⁹⁶

Conclusion

This part has defined the practice of preconception agreements, estimated their incidence, described their nature and participants, and stated what is known about the participants' motives.

To assist the legal and ethical analysis that follows in subsequent sections, preconception arrangements were defined on the basis of where the ovum originated, whether the carrying woman was paid, and whether a broker was involved.

Attempts to learn the incidence of the practice revealed the paucity of information on the subject and thus the need for research. What is clear is that the practice is growing, particularly in the United States where an estimated 50 percent of agreements are conducted by commercial agencies and where approximately 4 500 children have been born since 1978 as a result of the practice.

The exact nature of informal, oral agreements is not known, although some commercial brokers' arrangements are available. The agreements drafted for brokers Levin and Keane were introduced, and Keane's brokerage agreement was described in detail.

Demographic data regarding the participants revealed that carrying women and their partners, if any, tend to be younger, much less educated, and less affluent than commissioning couples. The motivations of carrying women, which we have discussed so far, have been identified by a proponent of the practice to include the desire to earn money, to give the "gift" of a baby, and to gain other advantages. Commissioners' motives can be varied. Some might wish simply to have a child to rear; others might want to be sure the child is genetically related to the commissioners. Commercial brokers and physicians who facilitate exclusively gestational arrangements appear to be motivated to earn money and to fulfil the desire of the commissioners. These motivations are discussed further in Part 3.

Part 2. The Enforceability of Preconception Agreements Under Ontario Law

Part 1 defined and described the practice of preconception arrangements. In this part, we consider whether a typical paid agreement between a commissioning man and a carrying woman (and her partner, if any) would be enforceable in Canada at the instance of the commissioning man. Only in Quebec is the answer clear. That province has passed legislation to make preconception agreements void and therefore unenforceable at law.¹ The legal position of preconception agreements in Canada's common law jurisdictions cannot be stated with certainty because none of the nine provinces and two territories has enacted legislation specific to the issue and no case concerning the matter has been brought

to a Canadian court. Nevertheless, it is possible to anticipate how a court in Canada's common law jurisdictions might rule on the question of the agreement's legal enforceability by analyzing the jurisdictions' analogous statutory and case law. This part chooses the law of Canada's most populous common law jurisdiction — Ontario — and considers how an Ontario court might view a preconception agreement. As shall be discussed, preconception arrangements appear to be governed by family law, not by contract law.

The Significant Provisions of a Preconception Agreement

An examination of three² commercial agreements drafted for or by American brokers reveals that they contain the following significant provisions:

1. The carrying woman agrees to become pregnant by the commissioning man's sperm, to carry the fetus to term, and then to transfer custody to the commissioning man and to relinquish her maternal rights to the child.³
2. The carrying woman and her husband promise to take all steps necessary to have the commissioning man's name entered on the child's birth certificate as the father, and the carrying woman's husband (if any) agrees to renounce any legal presumption that he is the child's father.⁴
3. Should custody of the child be awarded to anyone not related to the commissioning man (such as, for example, the carrying woman), the carrying woman and her husband (if any) promise to reimburse the commissioning man for all sums he is ordered to pay in child support.⁵
4. Should the commissioning man die before the child's birth, the carrying woman agrees to renounce her maternal rights and to transfer custody of the child to his wife, if any.⁶ Should he not be married or should his wife also die before the child's birth, the carrying woman agrees to transfer custody to the person the commissioning man has named in the agreement.⁷
5. The commissioning man promises to pay the carrying woman the specified sum (usually U.S. \$10 000) when her maternal rights are terminated by a court order and provided he has custody of the child.⁸
6. The parties agree that the specified fee can be radically reduced if the woman miscarries or gives birth to a stillborn child. In the *Baby M* agreement, for example, the carrying woman was to receive no payment if miscarriage occurred in the fourth month or earlier, and \$1 000 if the fetus miscarried subsequent to the fourth month or was born dead.⁹

7. The carrying woman promises that she will undergo an amniocentesis test.¹⁰
8. The carrying woman further agrees that she will not abort the fetus but that, if the commissioning man decides on the basis of the amniocentesis results that he does not want the child to be born, she will have an abortion.¹¹
9. The carrying woman promises not to form a parent-child bond with the fetus.¹²
10. The carrying woman agrees not to drink alcohol or to take any non-prescription, prescription, or illicit drugs without the permission of a named physician,¹³ and otherwise to adhere to all medical instructions of the attending physician.¹⁴
11. The commissioning man agrees to pay a number of expenses incurred by the carrying woman, such as medical, hospitalization, laboratory, and therapy expenses; and travel, accommodation, and child care costs.¹⁵

The enforceability of these provisions under Ontario law is the subject of the remainder of this part.

Legal Status of the Parties

To learn whether the participants' agreement is enforceable, it is necessary to establish the status of the parties.¹⁶ Such an inquiry incidentally reveals that the effectiveness of a preconception arrangement is limited even at its point of departure; although the agreements term the carrying woman the "surrogate mother" and the commissioning man the "natural father," Ontario law would determine parentage independently of the agreement.

Who Is the Legal Mother?

The first status question is, "Who shall be recognized as the mother of the child?" Section 1(1) of the Children's Law Reform Act (CLRA) states that, apart from cases of adoption, "for all purposes of the law of Ontario a person is the child of his or her natural parents and his or her status as their child is independent of whether the child is born within or outside marriage."¹⁷ Each of the preconception arrangements described above contemplates that the carrying woman will conceive by her ovum, gestate the fetus, and give birth to the child. In such cases, the carrying woman is not a so-called "surrogate mother" but, quite simply, the child's mother. As the child's mother, she would be considered the child's natural female parent for the purposes of Sec. 1(1) of the CLRA.

It is possible that the carrying woman would gestate an embryo that is genetically unrelated to her. In such a situation, she would stand in an exclusively gestational relationship to the child. Would she similarly be considered the child's mother and a "natural parent"? Ontario law is not

clear on this issue. Prior to the development and use of technology to bifurcate motherhood, there existed an incontrovertible presumption that the mother was the one from whose womb the child came.¹⁸ But now ovum donation and embryo transfer create a situation in which there are potentially two claimants to the title of "natural [female] parent": the woman from whom the ovum originated (the "genetic woman") and the woman who gestated and gave birth to the child (the "exclusively gestational woman").

While no Canadian court or statute has addressed the issue, there has been one litigated case in the United States of an exclusively gestational preconception arrangement in which two women sought to be recognized as the child's mother. In *Anna J v. Mark C.*,¹⁹ Crispina Calvert and her husband, Mark, hired Anna Johnson to carry and give birth to a child who originated from their gametes. When Johnson claimed custody on the grounds that she was the mother, the California Court of Appeal ruled that competing claims to maternity ought to be resolved in the same way as claims or denials of paternity: by blood tests. This analysis neglected to give any reasoned explanation for its conclusion that the ovum generator is more of a mother to the child than the woman whose body nurtured, protected, and gave birth to the child and presumably was prepared to continue nourishing it with breast milk.²⁰

Because the California court believed that the determination of maternity in an exclusively gestational arrangement was a matter of the interpretation of California statute rather than a question of policy, the decision is of little utility in resolving the issue in the context of Ontario law. For reasons to be developed in subsequent parts, this report recommends that the law recognize the gestational mother as the mother of the children to whom she gives birth, including those children conceived by the ova of other women.²¹

Who Is the Legal Father?

The second status question is, "Who will be recognized in law as the child's father?" According to Sec. 1(1) of the CLRA, the father is the child's "natural [male] parent."²² Provided, therefore, that the commissioning man's sperm actually participated in the child's conception, the commissioning man ought, according to Sec. 1(1), to be considered the child's father. But Sec. 1(1) is not the only applicable section. Section 8(1) sets forth a list of circumstances,²³ any one of which will give rise to a presumption as to whose sperm conceived the child. In the context of preconception arrangements, the effect of Sec. 8(1) is that a man other than the commissioning man (such as, for example, the carrying woman's husband) might be presumed to be the father. Although the presumption of paternity is rebuttable on the balance of probabilities,²⁴ it is not clear that a commissioning man would be successful in attempting to rebut the presumption. How he would go about making the attempt depends upon two factors: the carrying woman's marital status and her willingness to

acknowledge the commissioning man as the father. Whether the commissioning man would be successful in his attempt would ultimately turn on the court's estimation, in light of these two factors, of the child's best interests and the ethical nature of the preconception arrangement.

The commissioning man is most likely to obtain legal recognition of his paternity when the carrying woman is single²⁵ and willing to acknowledge him as the father. In such a case, there would be no presumption of paternity by any other man, and the woman would cooperate with the commissioning man in seeking legal recognition of his paternity. To do this, they would together make and register the statement required under the Vital Statistics Act's birth registration provisions that they are the mother and father of the child.²⁶ The commissioning man's act of thus certifying the child's birth as the child's father would give rise under Sec. 8(1)5 of the CLRA to a presumption of his paternity.²⁷ Because of the carrying woman's single status, there would be no competing presumptions; the presumption of the commissioning man's paternity would therefore prevail.²⁸ As the presumed father, the commissioning man could, under Sec. 4, seek and obtain a declaratory order that he is legally recognized as the child's father, unless it could be established on the balance of probabilities that someone else is the father.²⁹

Perhaps because it is easiest for a commissioning man to establish his paternity in the situation where the carrying woman is single and willing to acknowledge him as the father, there are no reported cases of disputes in these circumstances.

The second scenario is where the carrying woman is married³⁰ or cohabiting with a man³¹ and she is willing to acknowledge the commissioning man as the father. Among preconception arrangements, this is a common situation.³² As there is no reported case law in Ontario, it is not clear whether the commissioning man in this situation would achieve legal recognition as the child's father under Ontario law. If he has positive proof of his paternity in the form of a blood test, it seems certain that he would be entitled to recognition as the child's father.³³ Without such proof, however, his application might fail. Case law in the United Kingdom and the United States suggests that courts do not automatically grant a commissioning man's paternity-related application when the woman is married, even though she is willing to acknowledge him as the father. The decision to grant the application appears to depend on the court's view of the child's best interests and upon its attitude toward the preconception arrangement.

In this second scenario, where the carrying woman is married or cohabiting and willing to acknowledge the commissioning man as the child's father, the commissioning man would attempt to establish his paternity in much the same way as in the first scenario. Once his name appeared on the child's birth certificate, he would be presumed to be the child's father.³⁴ But because the woman was married or cohabiting with a man, that man would also be presumed to be the father.³⁵ Given that there

would be competing presumptions, neither presumption would operate and "no person [would be] recognized in law to be the father."³⁶ The most direct method for the commissioning man to obtain legal recognition of his paternity in this situation would be to make an application for a declaratory order under Sec. 4,³⁷ submitting in that application evidence of blood tests as proof that he is the natural father of the child. Since the carrying woman is willing to acknowledge his paternity, presumably she would freely submit herself and the commissioned child to the blood tests. Evidence of blood tests proving his paternity would establish that he is the child's natural father and therefore the man whom the law ought to recognize by virtue of Sec. 1(1) of the CLRA.³⁸

Case law demonstrates, however, that for the commissioning man in the second scenario it is not always easy to achieve judicial recognition of his paternity.³⁹ When trial courts have done so, they first found that their order was in the best interests of the child.

In the two English cases⁴⁰ where the court granted the unopposed application of the commissioning man in respect of a child born to a married woman, it specifically stated that concern for the child's best interests outweighed any other consideration. In *Re C*, Mr. Justice Latey denied that he should place primary importance on the ethical nature of the preconception arrangement:

First and foremost and at the heart of the prerogative jurisdiction in wardship, is what is best for the child and children concerned. That and nothing else. Plainly, the methods used to produce a child as this baby has been, and the commercial aspects of it, raise difficult and delicate problems of ethics, morality and social desirability. These problems ... are not relevant. The baby is here. All that matters is what is best for her now that she is here and not how she arrived.⁴¹

Because Latey J. found that the mother had abandoned the child and that the commissioning man was the father and that he and his wife were financially and emotionally equipped to care for the infant, the judge granted the commissioner's wardship application. Mr. Justice Latey did not raise the issue of the carrying woman's husband's possible paternity. Similarly, in *Re an Adoption Application (Surrogacy)*, which Latey J. also decided, the child's best interests prevailed over any other consideration.⁴²

In a third case⁴³ where a commissioning man obtained the order he sought in respect of a child born to a married woman, the court specifically stated that it granted the adoption order because to do so was in the child's best interests. Yet, unlike Latey J., the judge in the New York case of *Adoption of Baby Girl L.J.* seemed preoccupied not with the child's best interests upon which he did not elaborate, but with the ethical nature of the arrangements. Radigan S. decided that preconception arrangements represented a scientific advance not contemplated by New York statutes, which prohibit payment for adoption. In stating that the "scientific methods" enabled "childless couple[s]"⁴⁴ to have children, he tacitly

accepted the assertion of the commissioning man that he was the father. Without raising any question about the presumption of paternity in the carrying woman's husband, the court granted the commissioner's application.

In four other cases, however, courts have adopted a wary approach to preconception arrangements and refused to grant the commissioning man's request in respect of a child born to an unopposing married woman. In the Kentucky case of *Re Baby Girl*,⁴⁵ the judge was suspicious of the parties' application because, in his view, they were attempting to give effect to their preconception arrangement by circumventing adoption legislation. The parties sought to rely on the Kentucky Termination Act,⁴⁶ which permits mothers to renounce their maternal rights to the child. According to the court, however, they had not complied with that statute by placing the child with a licensed placement agency. Instead and in contravention of the Act, the mother had given the child directly to the commissioners. The court refused to allow the Termination Act to be used to "adjudge paternity of a child as sought in this action"⁴⁷ and held that affidavit evidence was insufficient to rebut the presumption that the carrying woman's husband was the child's father. The court held that there was a long line of cases requiring

clear and compelling proof to show that a child born to a husband and wife is an illegitimate child of a third person. The mere affidavit as to artificial insemination without other positive proof of non-access and blood grouping is not sufficient for this court to assume and adjudge the donor to be the natural and biological father of the child.⁴⁸

Similarly, in the District of Columbia case, *In re R.K.S.*,⁴⁹ the court was suspicious of the preconception arrangement. Salzman J. noted that "'surrogate mother' adoption procedures have been held invalid in other jurisdictions"⁵⁰ and that there was no evidence of the carrying woman's consent to the application. The judge ruled that the unsworn documents filed by the commissioning man were insufficient to rebut the presumption that the carrying woman's husband was the father. The court ordered *inter alia* that counsel investigate the feasibility of requiring human leucocyte antigen testing to be conducted to determine paternity. Salzman J. stated that to do so would be in the child's best interests.

In *Syrkowski v. Appleyard*,⁵¹ the commissioning man and carrying woman jointly sought a court declaration that the commissioning man was the father of the commissioned child. Two Michigan courts denied the application, which was opposed by the Attorney General who had intervened. On further appeal to the Michigan Supreme Court, the parties prevailed.⁵²

At both the trial and Court of Appeal levels in that case, the courts appeared concerned with the public policy implications of preconception arrangements. Although the members of the Court of Appeal did not rule as to whether the agreements contravened public policy, they expressed

their attitude to the arrangements thus: "We view the surrogate mother arrangements with caution as we approach an unexplored area in the law which, without a doubt, can have a profound effect on the lives of our people."⁵³ Consequently, the courts refused to allow the Michigan Paternity Act,⁵⁴ which was designed to provide support for children born out of wedlock, to "encompass the monetary transaction proposed in this case."⁵⁵ They therefore denied the commissioning man's application for recognition of his alleged paternity.

The Michigan Supreme Court, however, allowed the appeal, holding that the Paternity Act did in fact permit parties to preconception arrangements to use it to rebut the presumption of paternity by the carrying woman's husband and thereby to establish the commissioning man's paternity. In rendering that decision, the court made no reference to the child's best interests or to public policy regarding preconception arrangements, and expressed "no opinion about the plaintiff's entitlement to any other relief in the future,"⁵⁶ by which the court undoubtedly meant custody and adoption by the commissioning man's wife.

In the fourth and final case, a commissioning man's adoption application with respect to the child of a married woman who did not oppose the action was denied. In *Adoption of Paul*,⁵⁷ the New York court refused the application *inter alia* on the grounds that there was insufficient evidence to rebut the presumption of paternity by the carrying woman's husband (if any).⁵⁸ This decision was motivated by concern that the arrangements violated public policy and state statutes. Demarest J. found compelling the analysis and conclusion reached by the New Jersey Supreme Court in *Baby M*⁵⁹ that "surrogate parenting contracts [are] contrary to state policy and statutes and unenforceable."⁶⁰ The court held *inter alia* that the carrying woman would have to address the issue of the presumption of paternity before an adoption order could be made.

In the second scenario, therefore, the question of who will be recognized as the commissioned child's father is not answered quickly. If the commissioning man has blood test evidence of his paternity, it seems almost certain that an Ontario court would be obliged by Sec. 1(1) of the CLRA to grant his application, brought under Sec. 4 of the CLRA, irrespective of the court's view of the child's best interests and the ethical nature of preconception arrangements. If, on the other hand, he does not have blood test evidence, it is not clear whether an Ontario court would recognize his paternity either in a Sec. 4 application or as a matter ancillary to another proceeding, such as adoption. In the United Kingdom and the United States, similar applications were granted where the courts considered that to do so was in the best interests of the child. Where, however, the courts were suspicious of preconception arrangements, they tended to find that evidence of the carrying woman's artificial insemination in furtherance of the preconception arrangement was insufficient to rebut the presumption of paternity by the carrying woman's husband. Hence, even in cases where the carrying woman was willing to acknowledge the

commissioning man as the father, without proof by blood tests, some courts have held that the presumption of paternity in her husband had not been rebutted and that, therefore, the commissioning man could not be recognized as the legal father.

In the third scenario, the carrying woman is unmarried and not cohabiting with a man and is unwilling to acknowledge the commissioning man as the child's father. Would he be entitled to obtain judicial recognition of his paternity? Again, the answer under Ontario law is uncertain.

Because the carrying woman would be opposed to such an application, she would probably also refuse to allow the commissioning man to be named on the child's birth certificate. She might name some other man or refuse to acknowledge anyone as the father.⁶¹ In either case, the commissioning man has no independent right to amend the birth certificate.⁶²

The commissioning man might then bring a Sec. 4 application⁶³ for a declaratory order of his paternity. He might seek to rely on the preconception arrangement as evidence of his paternity. Whether, in the absence of blood tests, he would be successful would probably depend (as did the other cases we examined) on the court's view of the child's best interests and the ethical nature of the preconception arrangement.

Because the commissioning man's claim to paternity would be much stronger if he had evidence in the form of blood test results, he might bring an action for leave to obtain blood tests.⁶⁴ According to the Ontario Supreme Court in *H. v. H.*,⁶⁵ such an order will be granted where parentage is an issue except in those rare cases where a blood test would harm the infant or "where the application for the blood test is designed for some ulterior motive."⁶⁶ In the one case on this point, the California Superior Court ordered a single carrying woman who was unwilling to acknowledge the commissioning man as the child's father to submit to a blood test at the instance of the commissioning man who sought recognition of his paternity.⁶⁷

The fourth and final scenario is where the carrying woman is married or cohabiting with a man and she is unwilling to acknowledge the commissioning man as the child's father. It is in this scenario that the commissioning man seems least likely to gain legal recognition of his paternity.

Here, the commissioning man would (as was true in the third scenario) be unable to register his name on the child's birth certificate without the carrying woman's cooperation. Any action he brought under Sec. 4 of the CLRA for a declaration of paternity would be thwarted by the application of Sec. 4(2), which states that the presumed father is to be recognized as the legal father unless the contrary is proven on the balance of probabilities. Unless the commissioning man has blood test results, the carrying woman's husband or male partner would continue to be presumed to be the father. To obtain blood tests, the commissioning man would be required

to make a Sec. 10 application for leave to acquire the tests. Would he be successful in that application?

Despite the broad ruling in *H. v. H.*⁶⁸ that the court will order blood tests when parentage is an issue, a later Ontario case has held that there must be sufficient evidence to suggest that the presumption of paternity by the woman's husband is incorrect before the court will order the mother and child to submit to blood tests.⁶⁹ In a British Columbia case, the court refused to grant a male applicant leave to obtain blood tests where the mother was married and opposed the application and the court believed that the results of the tests would not be in the child's best interests.⁷⁰ Where the facts are the same except that there exists a preconception arrangement between the applicant and the defendant mother, it seems that unless an Ontario court is willing to accept evidence of the arrangement as sufficient to rebut the presumption of paternity, a commissioning man will probably be unsuccessful in his Sec. 10 application to obtain blood tests. Without those, his application for a declaratory order of his paternity would be unlikely to succeed.

Thus, we have seen that whether a commissioning man would be successful in obtaining legal recognition of his paternity is uncertain under Ontario law because the relevant statutes do not refer to preconception arrangements and there are no cases on point. If indeed he is the biological father, the commissioning man is entitled to be so recognized by virtue of Sec. 1(1) of the CLRA. How he would seek an order would depend upon the carrying woman's marital status and her willingness to acknowledge him as the commissioned child's father. When the court is in a position to exercise discretion in granting the order, its decision will undoubtedly be affected by its view of the child's best interests and its attitude toward preconception arrangements.

Legality of the Participants' Agreement

The previous section has demonstrated that the parental status of some of the participants in a preconception arrangement is uncertain. In the most common form of the practice — genetic-gestational arrangements — maternity is obvious and certain. It is not clear, however, whether a commissioning woman in an exclusively genetic arrangement or a commissioning man in either arrangement would be considered the commissioned child's natural parent or a stranger to the child. This uncertainty reveals two important matters. The first is that, though the agreement purports to be determinative of parental status, parentage would, in fact, be decided independently of the agreement.⁷¹ Secondly, uncertainty of parental status (usually only paternal status) can complicate legal analysis of the validity of the agreement, which must then be undertaken from two perspectives: where the commissioning man is the father and where he is regarded in law as a stranger to the child.⁷² Yet no matter whether a particular participant is considered a parent or a

stranger, analysis reveals that a preconception arrangement is probably not enforceable under applicable Ontario law. To demonstrate this, we must first determine what is the applicable law.

The Governing Law

At first blush, the preconception arrangement appears to be governed by the law of contract, for the parties clearly intended to create a legal relationship by which one offered and the other accepted, for valuable consideration, to undertake certain activities. Strangers to each other, they recorded their intentions in writing in the form of a commercial agreement. Ordinarily, courts will give legal effect to the intentions of competent adults so expressed.⁷³

If one looks, however, beyond the form of the agreement to its subject matter, the unusual nature of the putatively commercial contract is apparent. Far from being an agreement for the purchase of a house, the sale of a business, or the manufacture of widgets, the arrangement concerns the procreation, custody transfer, surrender, and adoption of a child. The agreement is an attempt to cast as commercial what has hitherto been considered familial. If one looks beyond the form of the agreement and its novelty, it appears to concern matters already governed by family law.⁷⁴

As evidence that the legal issues raised by genetic-gestational arrangements are not fundamentally new, consider the case where the law recognizes the commissioning man to be the father. In requiring the mother to transfer custody of the child and to terminate her maternal rights, and in thus making it possible for the commissioning woman to adopt the child, the agreement is simply an attempt to effect a step-parent adoption. Where the commissioning man is not recognized as the father, the arrangement would require both the carrying woman and her husband to sever their parental rights to the child and to transfer custody to the commissioners who, as legal strangers to the child, would adopt. Here, the preconception arrangement attempts to effect a "stranger" adoption.

Once it is apparent that preconception arrangements are not fundamentally different from situations that the law has addressed in step-parent adoption and stranger adoption, it also becomes apparent why their contractual form is suspicious. Even though the agreements concern not goods or services but the legal relationships of adults to children, they purport to be governed according to the legal standard by which courts give effect to contracts for goods and services, *viz.* the intentions of the adult parties. In agreeing to alter their relationships to the child exclusively according to their own desires expressed before the child's conception, the parties purport to treat the child like a moveable, manufactured product — like a chattel or commodity — and to arrogate the power to dictate the legal status of the commissioned child. The law of contract may apply to govern the agreement only if these two purposes can legally be achieved.

But of course they cannot. As the Supreme Court of Canada has ruled, "a child is not a chattel in which its parents have a proprietary interest; it is a human being to whom they owe serious obligations."⁷⁵ As a vulnerable human being, a child may not be contracted about in a manner dictated exclusively by the interests of the adults. In agreements concerning the legal relationships among adults and children, family law applies and uses a standard different from that of contract law: it considers not primarily adults' wishes but adults' responsibilities, and is guided not by the interests of the adults but by the interests of the child. According to the Supreme Court of Canada, it is precisely because the best result for a child might not be achieved by giving effect to the wishes of adults that the legislature has empowered courts to override adults' desires. Family law denies adults the ultimate power to dictate their legal relationships with children because it recognizes "an aspect of the human condition — that our own self-interest sometimes clouds our perception of what is best for those for whom we are responsible."⁷⁶

Thus, because preconception agreements concern the legal relationships among adults and children, not chattel, family law applies. Because family law applies, the self-interest of adults cannot reign but may be circumscribed by the interests of the child. As shall be demonstrated, Ontario family law would probably render unenforceable each of the central provisions of a preconception agreement to the extent that, in aiming to satisfy the self-interest of the parties as understood prior to conception, they treat as irrelevant the best interests of the child.

In addition to the central provisions of a preconception agreement that relate to the commissioned child, there are ancillary provisions in the agreement concerning primarily the relations between the adults *inter se*. For reasons to be discussed below,⁷⁷ these ancillary provisions are arguably also unenforceable.

Enforceability of the Provisions of a Preconception Agreement

The Central Provisions

There are four central provisions in a preconception agreement that purport to affect directly the legal relations among the adult parties and the commissioned child. These provisions concern (1) custody transfer of the commissioned child;⁷⁸ (2) relinquishment of the carrying woman's maternal rights;⁷⁹ (3) payment by the commissioning man to the carrying woman for transferring custody and relinquishing her maternal rights, thus making it possible for the commissioning woman to adopt the child ("payment for adoption");⁸⁰ and (4) adoption by the commissioning woman and/or the commissioning man.⁸¹ The legal enforceability under Ontario family law of each of these provisions will be treated in turn.

Custody Transfer of the Commissioned Child

At the heart of a preconception arrangement is the carrying woman's promise to transfer custody of the commissioned child at birth to the commissioning man. Yet, in Ontario, an agreement to transfer the custody

of a child is unenforceable if the transfer is not in the child's best interests. Although judicial and legislative interpretations of what constitutes a child's best interests have varied over time,⁸² consideration for the welfare of the child has long determined the enforceability at common law, and now also by statute, of agreements to transfer the custody of children.

At common law, the right to the custody of legitimate children historically resided in the father, even when contested by the mother, because it was believed to be in the child's best interests to remain in the care of its father. According to Lord Chancellor Eldon in 1803, the father's right "was thrown upon him by the law, not for his gratification, but on account of his duties."⁸³ Custody was a right granted to the father so that he could fulfil his responsibilities toward his children.⁸⁴ For this reason, agreements by which fathers transferred custody of their children even to the children's mother were generally regarded as contrary to public policy and therefore void. As the Master of the Rolls explained in 1865,

a covenant by a father that he will abstain from seeing and exercising any control over his children, is bad, because it is against the policy of the law, which holds that it is desirable that a father should exercise superintendence over his children, and that he cannot therefore by contract deprive himself of this inherent right and duty.⁸⁵

Most of the cases concerned agreements by fathers to surrender custody. Dicta, however, made it clear that the judicial position that parental rights were not transferable by agreement extended to mothers as well.⁸⁶

While generally holding that agreements to transfer the custody of children were not in a child's best interests and therefore unenforceable, courts recognized that the welfare of the child sometimes required the enforceability of an agreement to transfer parental rights and duties. For example, the court refused to interfere in a custody arrangement consented to by the father under which a child was thriving in the home of a maternal aunt.⁸⁷ Likewise, the court refused to nullify an agreement by which the father transferred custody of his two children to their mother where the father was suspected of sexually abusing his daughter.⁸⁸ When the custody agreement conferred a positive benefit or avoided harm, courts recognized it; to do so was in the best interests of the child. Thus, both the general rule of non-enforceability of custody agreements and the exceptions were based upon the same principle: the welfare of the child.⁸⁹

Canadian courts adopted this common law rule of giving effect to agreements to transfer custody only if they were believed to be in the best interests of the child. In the 1882 Ontario decision, *Roberts v. Hall*,⁹⁰ Chancellor Boyd affirmed the existence of the general rule that "the Court will not allow or assist a father to make any arrangement which will preclude him from acting according to his judgment and discretion in the most advantageous manner for the welfare of his child."⁹¹ Boyd C. also recognized that exceptional circumstances could arise that would justify a custody agreement, such as where the transfer was intended to benefit the

child or to remove him or her from harm. The question for the court was whose interests were aimed to be served by the agreement. As Boyd C. stated, "the real point is, was the arrangement one *bona fide* intended for the benefit of the child, or was it a colourable attempt to contravene the policy of the law?"⁹² The policy of the law was that parents should act in the interests of their children.

Whether parents are indeed acting in the interests of their children is open to question when their own interests are advanced by the custody transfer. For this reason, Canadian courts have been highly suspicious of custody agreements that profit the transferring parent. As long ago as 1908,⁹³ the Supreme Court of Canada expressed its hostility toward custody transfer agreements that benefit the parent. In enforcing an agreement by which a mother transferred legal guardianship of her daughter to her father-in-law so that the child could have a good education, the Court nevertheless stated emphatically that a custody transfer arrangement that fostered the interest of the parent would be void:

If all these family arrangements were indeed a mere cloak to hide and cover up an improper attempt to contravene the policy of the law, as by a natural guardian selling her right as such to another for a consideration, or a mother formally abdicating alike her rights over and her duties towards her child for a personal benefit to herself, the argument against the validity of the arrangement so far as it so attempted to contravene such policy would be irresistible.⁹⁴

Judicial suspicion of custody arrangements that profit the transferring parent has remained strong. In 1973, an Ontario Provincial Court Judge refused to enforce an agreement whereby the father waived his rights of access in order to avoid his obligation to pay maintenance.⁹⁵ Likewise in 1976, the British Columbia Supreme Court held void an agreement by which the father relinquished his paternal rights to the child in exchange for the mother's conveyance to him of her interest in the former matrimonial home.⁹⁶ In the court's opinion, the agreement was not a "proper general 'family arrangement' by which the parties composed their differences over property matters and children" because

there [was] not the slightest indication in the evidence that, in agreeing to give his consent to adoption, the defendant father was motivated by any consideration involving the welfare of his children but, to the contrary, in my view, he was wholly motivated by his desire to acquire his former wife's interest in their property ... He sold his consent; in practical effect he bargained away his rights and duties as a father for a valuable consideration.⁹⁷

The court held that the arrangement between the former spouses was prejudicial to family life, involving the abrogation of parental duties and rights, and was therefore void as being contrary to public policy.

Thus, at common law, the test of the enforceability of a custody transfer agreement is whether the agreement promotes the best interests

of the child. This common law test has been adopted and codified by Ontario and Canadian statute law: under the Family Law Act (FLA),⁹⁸ the CLRA,⁹⁹ and the Divorce Act,¹⁰⁰ agreements regarding the custody of children are enforceable only to the extent that they promote the children's best interests.

The FLA specifically permits persons in intimate relationships to enter into agreements concerning domestic matters. These "domestic contracts" are of three types: cohabitation agreements, marriage contracts, and separation agreements. A cohabitation agreement may be made by a woman and a man who are living together in a conjugal relationship or are intending so to do.¹⁰¹ A marriage contract may be entered into by a woman and a man who are married or are intending to marry.¹⁰² Women and men who have cohabited but are living separate and apart may enter into separation agreements.¹⁰³

Under the FLA, the parties to cohabitation agreements and to marriage contracts may not agree about the right to custody of, or access to, their children.¹⁰⁴ It appears that the legislature limited the parties' freedom in this way because it assumed that custody and access provisions in these domestic contracts might not be in the interests of the children. The children of cohabiting or married couples either are not yet in being or are living with the adult parties; the children's interests in the possible event of the parents' separation cannot be known in advance of the event. Because, therefore, a provision in a cohabitation or marriage agreement regarding custody or access could not be made with respect to the best interests of the child at separation, such a provision is void.

Consistent with the view that the best interests of children at separation can be known only at the time of the separation, the FLA does permit parties who have cohabited but are living apart to enter into an agreement to govern custody and access to children.¹⁰⁵ But even though these two parties are permitted to decide between themselves who shall have custody and access to the child upon separation, the FLA provides that "the court may disregard [their agreement] ... where, in the opinion of the court, to do so is in the best interests of the child."¹⁰⁶

Just as the child's best interests limit adults' freedom to agree about custody in advance of separation, and determine the enforceability of an agreement made at separation, so too does the best interests test govern judicial orders for custody. Adults may apply to a court for custody under Sec. 21 of the CLRA¹⁰⁷ or Sec. 16 or Sec. 17 of the Divorce Act.¹⁰⁸ Both Acts require that the court decide custody on the basis of the best interests of the child.¹⁰⁹ Section 24(2) of the CLRA sets out statutory criteria to assist the court in determining what constitute the best interests of the child. It states:

- ... a court shall consider all the child's needs and circumstances, including,
- (a) the love, affection and emotional ties between the child and,
 - (i) each person seeking custody or access,

- (ii) other members of the child's family residing with him or her, and
- (iii) persons involved in the child's care and upbringing;
- (b) the child's views and preferences, if they can reasonably be ascertained;
- (c) the length of time the child has lived in a stable home environment;
- (d) the ability of each person seeking custody or access to act as a parent;
- (e) the ability and willingness of each person seeking custody to provide the child with guidance, education and necessities of life and to meet any special needs of the child;
- (f) any plans proposed for the child's care and upbringing;
- (g) the permanence and stability of the family unit with which it is proposed that the child will live; and
- (h) the relationship, by blood or through an adoption order, between the child and each person who is a party to the application or motion.

With this range of considerations in mind, a judge acting under the CLRA is required to make a custody order that will promote the best interests of the child.

Thus, both at common law and by statute, Ontario determines the enforceability of agreements regarding the custody of children on the basis of a single test: the best interests of the child. When one turns to consider preconception agreements against this background, it appears that such agreements fail to meet this test.

Preconception agreements give rise to the same concern as cohabitation agreements and marriage contracts that purport to determine custody in advance of the possible event of separation: in both preconception agreements and these domestic contracts, the adult parties at the time of contracting have an inadequate appreciation of the child's interests. To make a custody arrangement in the best interests of the child, the adult parties would arguably need to be in a position to consider the range of issues set forth in Sec. 24(2) of the CLRA¹¹⁰ and presented above. Yet, because in a preconception arrangement the child is, by definition, not yet in being, its particular needs and circumstances cannot be known. For example, it is not possible for the parties to appreciate before conception the emotional ties that will develop between the child and the other members of the carrying woman's family.¹¹¹ Similarly, the carrying woman is not well positioned before conception to assess the parenting ability of the commissioning couple whom she might not know and who might not have children, and of the person named in the agreement, whom the carrying woman might never have met, who is to have custody in the event of the commissioner's death.¹¹² Moreover, if the child is born with a handicap such as blindness, its needs might be completely other than can be met by the agreement.¹¹³ Because the participants in a preconception

arrangement, by definition, do not know the child when they make their agreement, they cannot make a decision in the knowledge that it will be in the child's best interests. For the same reasons that Ontario statute law renders unenforceable agreements about custody made in advance of separation, so too might it render unenforceable agreements made in advance of conception.

Not only do preconception arrangements purport to transfer custody of the commissioned child with an inadequate appreciation of the child's best interests, but they aim to do so in circumstances that suggest that the self-interest of the adult parties is the central goal. Where the carrying woman receives a financial benefit or other consideration for relinquishing custody, her self-interest arguably motivates her decision to enter the arrangement; this motivation is contrary to the best interests test.¹¹⁴ The commissioning man similarly appears to be acting solely in his own interests. By requiring the carrying woman to reimburse him for any child support he is ordered by court to pay in the event he does not gain custody, the commissioning man evinces a lack of concern for the child's well-being; if the carrying woman needs the court-ordered support to care for the child, her attempts to reimburse the commissioning man will be to the detriment of the child. Further, to the extent that the commissioning man reserves the right to refuse to accept a child born *because of* the agreement (in the sense that the carrying woman was willing to conceive) but not *according to* the agreement (in that she conceived — perhaps inadvertently — by the sperm of another man), he is not concerned with the child's interests but his own self-interest in fathering a genetically related child.

Thus, at common law and by statute, Ontario has a single test of the enforceability of an agreement to transfer the custody of a child: the best interests of the child. A preconception agreement cannot meet that test because, at the time it is made, the child's interests are not known. Moreover, by accepting financial or other reward for relinquishing custody, by requiring child support indemnification, and by refusing to accept custody of a child born because of, but not according to, the agreement, the adult parties demonstrate in the agreement itself that their bargain aims primarily to promote their own interests and only incidentally those of the commissioned child. For these reasons, a preconception agreement would probably not be enforceable in Ontario in advance, or at the time, of the child's birth except if it coincidentally appeared that to do so was in the child's best interests.

The Carrying Woman's Relinquishment of Maternal Rights

The second central provision of a preconception arrangement is the consent given by the carrying woman before conception to relinquish her maternal rights to the child at birth. Such consent is clearly invalid under Ontario law.

The Child and Family Services Act (CFSAct)¹¹⁵ governs the circumstances in which parents may relinquish their rights and duties

toward children in adoption.¹¹⁶ Section 131(2) stipulates that, to make an order for adoption, the court must first have the written consent of every parent. Under Sec. 131(3), a parent may not give consent to adoption before the child is seven days old¹¹⁷ and may revoke that consent in writing within 21 days thereafter.¹¹⁸ The putative irrevocable consent by the carrying woman in a preconception agreement is therefore of no legal effect.¹¹⁹

With respect to birth mothers, the principle underlying this statutory provision appears to be that a woman cannot know the depth of her desire to rear her child until she has given birth and that, because giving birth is an exhausting and emotional process, she ought to be given at least one week to recover before any decision to relinquish the child has legal force. Because of the finality of an adoption order and the fact that she has no standing in the adoption process once her consent is validly given,¹²⁰ a birth mother is allowed a grace period of 21 days in which to change her mind.

Although it has been argued that these considerations underlying the consent procedure in adoption are irrelevant in preconception arrangements, the same concerns do in fact prevail. Chicago legal commentator Lori B. Andrews¹²¹ claims that the very fact that the carrying woman agrees to relinquish her maternal rights before conception enables her to make a reasoned decision: "she can make an informed, unemotional reflection about whether she wants to bear a child for another couple."¹²² According to Andrews, "a surrogate contract should be enforced and the surrogate held to her promise to turn over the child"¹²³ because, *inter alia*, "research on surrogates ... indicates most surrogate[s] ... are able to determine in advance what their response will be."¹²⁴

This argument does not, however, undermine the principle of making valid only a temporarily revocable consent given seven days after birth. Even if carrying women can decide unemotionally whether they wish to bear a child for a couple, they probably cannot anticipate how they will feel when they carry and give birth to the child. It is possible that the carrying woman will experience the same range of feelings as did the mother in the Supreme Court of Canada case of *K.K. v. G.L. and B.J.L.*¹²⁵ According to McIntyre J., even though the mother in that case resolved before the birth to surrender the child for adoption,

The birth of the child aroused in the mother a surge of maternal love and affection for the baby, far exceeding any expectation. She changed her mind about the proposed adoption almost at once. She became reluctant to give up the child.¹²⁶

Even if the research upon which Andrews relies but does not cite is accurate in claiming that most carrying women can determine in advance what their response will be, the provision in Sec. 131(3) of the CFSA does not prevent them from acting upon their desire to relinquish the child, but merely stipulates when they may validly consent to relinquish the child.

Section 131(3) makes clear that consent given in advance is invalid; a carrying woman who incorrectly anticipates her response to her pregnancy and childbirth is not bound by her preconception consent and has the same rights and duties as other mothers with respect to their children. Therefore, the provision in preconception agreements purporting to relinquish maternal rights to the child in advance of its birth is of no legal effect.¹²⁷

Payment for Adoption

In paid preconception agreements, the commissioning man promises to pay the carrying woman a substantial fee (usually about U.S. \$10 000) when her maternal rights are terminated by court order and provided that he has custody of the child.¹²⁸ But Sec. 159 of the CDSA provides in very broad language that payment for adoption is prohibited. It states, in part:

159. No person, whether before or after a child's birth, shall give, receive or agree to give or receive a payment or reward of any kind in connection with,
 - (a) the child's adoption or placement for adoption;
 - (b) a consent under section 131 to the child's adoption; or
 - (c) negotiations or arrangements with a view to the child's adoption.

Section 160(4) provides that a contravention of this provision is an offence punishable by a fine of not more than \$25 000 or by imprisonment for a term of not more than three years or both. Because paid preconception arrangements involve, at minimum,¹²⁹ payment for the carrying woman's consent to relinquish her parental rights, they violate Sec. 159 of the CDSA. That section would make both the carrying woman and the commissioners punishable for the offence.

It might be argued, as it was successfully before the Supreme Court of Kentucky,¹³⁰ that preconception arrangements do not, in fact, involve adoption and therefore do not violate Sec. 159. Such an argument would rely upon the absence of any mention of the term "adoption" in the agreement itself and the arguments accepted by the majority of the Kentucky Supreme Court. But this contention would likely fail because an Ontario court might well look beyond the form of the arrangement to its substance and rely not on the flawed reasoning of the Kentucky majority but upon the more lucid analysis of the minority in that case, and of the New Jersey Supreme Court in *Baby M.*¹³¹

In *Surrogate Parenting Associates v. Commonwealth of Kentucky ex. rel. Armstrong (SPA v. Armstrong)*,¹³² the Kentucky Attorney General attempted to revoke SPA's corporate charter. The Attorney General argued that, as a "surrogacy" broker, SPA violated the statutory prohibition against purchasing children for the purpose of adoption. In a 6 to 2 decision, however, the majority held that SPA's involvement in preconception arrangements did not violate Kentucky law.

The majority conceded that the prohibition against payment for adoption was intended to prevent expectant mothers and parents from being overwhelmed by financial inducements to part with their children. Yet they held that this concern did not arise in a preconception arrangement because there the carrying woman agrees to relinquish the child not through fear of an unwanted pregnancy or of the financial burden of child-rearing, but through the desire to assist a person or couple who desperately want a child but are unable to conceive one. The majority apparently believed that a woman who agreed before conception to relinquish her child could not be subject to financial inducement to part with her child; they appeared not to contemplate that the mother's intentions might change, that she might not want to surrender her baby once she saw it, and that the \$10 000 might thus constitute financial inducement to relinquish her child.

The majority also made the surprising assertion that the process by which a woman is inseminated with the commissioner's sperm, conceives, gestates, gives birth, and then surrenders the child "is not biologically different from the reverse situation where the husband is infertile and the wife conceives by artificial insemination."¹³³ The majority held that, because artificial insemination of the wife of an infertile man does not violate the adoption law, preconception agreements do not violate adoption laws. It is, however, clear that the lengthy and intimate process by which a woman nurtures, and develops a relationship with, a fetus as it grows inside her body and by which she must labour to give birth in pain and blood is in no way analogous to the brief and painless act of a man producing a sperm sample. Preconception arrangements are not comparable to donor insemination because the experiences of conceiving, bearing, and giving birth to a child, on the one hand, and donating semen, on the other, are not similar. Moreover, in the case of a man donating semen, the financial inducement is for him to part with his semen — not his child. (The more approximate analogy in the case of a woman is for her to part with an ovum, but even this is not the same because parting with semen is not invasive and painful, as is the technique to extract ova.)

Proceeding nevertheless from this inapposite analogy, the Kentucky majority said that, because adoption by the infertile husband of the semen donor's child does not violate adoption laws, adoption by the commissioning woman of the carrying woman's child similarly ought not to be a violation of adoption laws. Here the court was confused about the purpose of the payment ban. The law against payment for adoption is not designed to protect semen donors or disinterested fathers from financial inducements to part with their children. It is designed to protect mothers and interested fathers. Semen donors are not vulnerable to the financial inducement to relinquish children that it was the purpose of the Kentucky statute to prevent.

In concluding, the majority again made a surprising statement:

The advances of biomedical science have carried us forward, willingly or otherwise, into a new era of genetics ... The courts should not shrink

from the benefits to be derived from science in solving these problems simply because they may lead to legal complications. The legal complications are not insolvable.¹³⁴

The majority incorrectly believed that there was something new and scientific about human conceptions that occur because of sexual intercourse or because of insemination effected by a device often as technically unsophisticated as a syringe or a turkey baster. Because of this ill-founded concern for scientific progress, the majority held that the judiciary should overlook the "legal complications"¹³⁵ presented by laws designed to prevent women from being induced to part with their children by the promise of money.

The two minority opinions in the Kentucky case more persuasively analyzed the issues at stake and found SPA's activities in violation of the law prohibiting payment for adoption. Mr. Justice Vance held that SPA's primary purpose was "to locate women who will readily, for a price, allow themselves to be used as human incubators and who are willing to sell, for a price, all of their parental rights in a child thus born."¹³⁶ Because under SPA's arrangements the last portion of the payment was made only once the carrying woman's maternal rights were terminated, the money was clearly payment for the baby. The second dissentient, Wintersheimer J., also strongly condemned the arrangement. In his view,

The procedure endorsed by the majority is nothing more than a commercial transaction in which a surrogate mother receives money in exchange for terminating her natural and biological rights in the child. This permits the infant to be adopted by the infertile wife and apparent biological father. The apparent biological father is obviously not adopting his own child but actually purchasing the right to have the child adopted by his own infertile wife ... [T]he commercialization of this type of personal problem is exactly what [the Kentucky statute] is intended to prevent.¹³⁷

He said that, although the contracts went to great length to avoid mentioning adoption or including any specific reference to the infertile wife, this did not prevent a reviewing court from recognizing the true nature of the commercial transaction involved. He considered that the purpose of the language of the agreement was merely to avoid the Kentucky statute and that it was an obvious subterfuge. Moreover, he believed that the arrangements could be exploitative, for even if there might be some altruistic women who would volunteer as surrogate mothers, monetary payment would be necessary to induce most carrying women's participation. According to Wintersheimer J., the price at which a woman would sell her reproductive capacity would depend on her financial status, and therefore financially needy women might be induced by the payment to make their children available for adoption in exchange for money. For these reasons, he disagreed with the majority and found the agreements void.

Like the minority in *SPA v. Armstrong*, the New Jersey Supreme Court in *Baby M*¹³⁸ held that a paid preconception arrangement created a

situation that New Jersey law aimed to prevent with its prohibition on payment for adoption. The court looked beyond the agreement's form to its substance; although the drafting attempted to style the fee as "payment for services," the court held that the payment was for the adoption of the child. It noted that, under the arrangement, the carrying woman would receive no money in the event of a miscarriage before the fourth month of pregnancy, and that she would receive only \$1 000 if there were a miscarriage or stillbirth subsequent to that date. Even though a pregnancy carried to term and ending in stillbirth would constitute the fulfilment of the gestational services, the carrying woman would receive only one-tenth her fee. The court therefore reasoned that the payment was for a live baby, not for gestational services.

Moreover, that the payment was not merely for the birth of a live baby but for its adoption by the commissioners was apparent in the intentions of all the parties. They all knew that the commissioning woman intended to adopt the child. Indeed, one of the carrying woman's estimated costs, to be assumed by the commissioning man, was an "adoption fee" presumed by the court to reimburse the carrying woman for incidental costs in connection with the adoption. In strong language, the court refused to accept the arguments of the commissioners that no adoption was contemplated.

It strains credulity to claim that these arrangements, touted by those in the surrogacy business as an attractive alternative to the usual route leading to adoption, really amount to something other than a private placement adoption for money.¹³⁹

According to the court, the policy reasons against private placement adoptions for money were applicable also in paid preconception arrangements. The child was sold without regard for whether the purchasers would be suitable parents, and the natural mother did not receive the benefit of counselling and guidance to assist her in making her decision and to inhibit the coercive nature of the payment. Moreover, the "baby-selling"¹⁴⁰ had the potential to result in the exploitation of all the parties involved. The New Jersey Supreme Court thus found that the *Baby M* preconception agreement constituted payment for adoption in circumstances that gave rise to the concern motivating the legislative ban against such payment. Consequently, the court held that the arrangement violated New Jersey law and was therefore void.¹⁴¹

Given the strength of these arguments, it seems likely that an Ontario court would similarly hold that paid preconception agreements violate Ontario's statutory ban on payment for adoption contained in Sec. 159 of the CFSA.

Adoption by Commissioner(s)

As we have seen, preconception arrangements drafted by commercial brokers do not explicitly involve an adoption. But as was made clear by both the Kentucky minority¹⁴² and the New Jersey Supreme Court,¹⁴³ the

purpose of a preconception arrangement is to enable a commissioner or commissioners to circumvent the traditional path to adoption. The question here is whether the parties may thus implicitly agree to the placement for adoption of the commissioned child in the commissioners' home.

In Ontario, the process of adoption is governed by the child welfare legislation set forth in the CFSA.¹⁴⁴ Adoption may occur under Crown wardship or by private adoption. The first would rarely be relevant in the context of preconception arrangements and will not therefore be discussed here.¹⁴⁵ In private adoption, parents must give valid consent. Within the private adoption process, there are two distinct streams: family and "stranger" adoption. The former stream involves an adoption by a step-parent or relative and does not require supervision by a state agent.¹⁴⁶ Nevertheless, it does require a court order approving the adoption, which will be discussed below. In the "stranger" adoption process, adoption agencies and licensees supervise the process and match adoptive parents and children.¹⁴⁷ Licensees must be non-profit organizations.¹⁴⁸

Irrespective of whether the intended adoption is a family or "stranger" adoption, the parties must apply to the Provincial Court (Family Division) for an adoption order.¹⁴⁹ In making that order, the judge is governed by legislative restrictions set out in Secs. 140-147 of the CFSA, the most important of which is that the adoption order may be granted only if it is in the child's best interests.¹⁵⁰

When commissioners attempt to adopt the commissioned child, an initial issue to be resolved is whether they may make their application through the route that is most advantageous¹⁵¹ to them: the family adoption route. Commissioners would argue that, where the commissioning man is the natural father of the child, he is not required to adopt the child; the adoption by his wife would be a step-parent (and therefore a family) adoption. That commissioners may take this route is the position of one commentator, who writes,

The step-parent adoption model relates more directly [than the stranger adoption model] to surrogate agreements in which a woman surrenders to its biological father the child to which she has given birth. Because of his biological and legal paternity, the father does not have to adopt his child nor seek the judicial or other approval for the discharge of his responsibilities toward the child.¹⁵²

This position assumes that the commissioning man is, in fact, the natural father and that this fact will be given legal recognition. But, as we have seen in the section entitled "Legal Status of the Parties" (above), obtaining the legal status of paternity can be problematic. Assuming, however, that the commissioning man does achieve legal recognition as the child's father, it appears that the family adoption procedure would be open to him.¹⁵³ Yet because of the broad powers given to the court to make an adoption order in the child's best interests, the court, under Sec. 143(6), may require in

effect that the adoption application be treated, in part, as a "stranger" adoption application.

Section 143(6) gives the court power to order that the state-approved director file a written opinion based on a report of the child's adjustment in the applicant's home, indicating whether the director believes it is in the child's best interests to make the adoption order. In this way, the state would have power after the placement, though not before, to assess whether the commissioners are suitable parents for the child. The argument for exercising jurisdiction under Sec. 143(6) is that preconception arrangements are unlike family adoptions, in that the parents generally have never shared an intimate relationship, but are united only by an unenforceable commercial agreement; therefore they are ill positioned to assess each other's parenting ability. Further, unlike most family adoptions, where a child has been living with the custodial parent (usually its mother, who has separated from its father) and is adopted by the custodial parent's new spouse, the commissioned child is placed for adoption with people with whom it has previously had no relationship; both the commissioning man and the commissioning woman are strangers to the child. Because the participants in a preconception arrangement are generally strangers to each other and the commissioners are strangers to the baby, the proposed adoption is, from the perspective of ensuring the achievement of the best interests of the child, more analogous to "stranger" than to family adoption.¹⁵⁴

Irrespective of whether the proposed adoption is by the family or stranger route, the court cannot make an adoption order simply because to do so is in the interest of the adult applicants, but only because the adoption would be in the best interests of the child. In cases involving preconception arrangements in the United States and United Kingdom where the court has approved adoption applications, it has done so on this basis.¹⁵⁵ It has refused applications where the mother's consent was given prior to conception and for payment, which prevented her from consenting in the child's best interests.¹⁵⁶

Thus, despite the implicit understanding among the parties that (at least) the commissioning woman will adopt the child, whether their implicit agreement can be effected in Ontario would ultimately depend not upon the adults' desires but upon the court's assessment of the best interests of the child.

By examining the enforceability of the four central provisions of the preconception agreement, we have seen that the test of enforceability would not be the idealized contractual test of whether the parties consented (without fraud, duress, and unconscionability) to a bargain believed to be in their self-interest. On the contrary, the sole test of whether the parties could achieve their objectives as set forth explicitly and implicitly in a preconception agreement is whether the particular objective is in the best interests of the child.

Ancillary Provisions

In addition to the four central provisions of a preconception arrangement that fundamentally affect the child's status, there are ancillary provisions that are also of questionable enforceability. These provisions purport to circumscribe the carrying woman's liberty during her pregnancy and to transfer medical decision-making power from her to the commissioning man and his agents.

As was described above,¹⁵⁷ in the preconception agreements under study, a carrying woman promises in advance of conception that she will submit to amniocentesis; that she will abort the fetus upon the commissioning man's demand but not otherwise; that she will not form a parent-child bond with the fetus; that she will not drink alcohol or take non-prescription, prescription, or illicit drugs without the permission of a physician (who might be chosen by the commissioning man); and that she will adhere to all medical instructions of the attending physicians. Under Ontario law, these provisions are not enforceable by the commissioning man.

The promise to undergo amniocentesis constitutes, in effect, consent to a surgical procedure. That consent may be revoked at any time prior to the performance of the procedure.¹⁵⁸

The provision compelling or preventing an abortion at the instance of the commissioning man is also unenforceable. The right of a woman to make decisions about whether she will carry a fetus to term on the basis of her own priorities and aspirations is constitutionally¹⁵⁹ protected by section 7 of the *Canadian Charter of Rights and Freedoms*.¹⁶⁰ Since a woman's priorities and aspirations might change, a putative contractual waiver of the constitutional right in advance of conception would invalidly limit the exercise of a fundamental freedom and is, therefore, unenforceable.¹⁶¹ Not only would a commissioning man be thwarted in an attempt to rely on the agreement to have standing to prevent or compel an abortion, he would have no independent status as a prospective father to achieve the same goal. In a unanimous decision, the Supreme Court of Canada in *Tremblay v. Daigle* refused to accept the argument that "a father's interest in a foetus which he helped create could support a right to veto a woman's decisions in respect of the foetus she is carrying."¹⁶²

This ruling is sufficiently broad to suggest that a commissioning man has no standing independent of the agreement to regulate what the carrying woman ingests, and whether she follows medical advice or forms a bond with the child. Any attempt to rely on the agreement to seek either an injunction to restrain the breach of the negative stipulations (i.e., the promises not to ingest certain substances and not to develop a parent-child bond) or specific performance of the agreement to obey the physician is certain to fail. The remedies of injunction and specific performance are equitable and discretionary.¹⁶³ They almost certainly would not be granted to a commissioning man in this context.

Conclusion

This part has considered the legal effectiveness in Ontario of preconception arrangements drafted by or on behalf of commercial brokers. No arrangement has yet been litigated in Ontario or elsewhere in Canada, so it is not clear how common law courts will regard them. Nevertheless, we have seen that, although the arrangements purport to determine the parties' parental status, that matter would probably be resolved under Ontario law independently of the arrangements and perhaps in a manner different from that originally intended by the parties. Further, although the agreement is cast in the form of a commercial contract, its subject matter appears to be that of family law. Its four central provisions affecting the child would likely be decided under Ontario family law, which would resolve any disputes arising from the provisions not on the basis of adults' desires but according to the commissioned child's best interests. Only by satisfying this test could the parties achieve a court order corresponding to their intentions expressed or implied in the four central provisions. The ancillary provisions in the preconception arrangement, which affect primarily the liberty of the carrying woman with respect to her pregnancy, would be unenforceable at the instance of the commissioning man and the commissioning woman, if any.

Part 3. An Analysis of the Common Description of the Practice of Preconception Arrangements

Introduction

The legal analysis in Part 2 concluded that preconception agreements would likely be regarded as void and unenforceable under Ontario family law. This conclusion was based on the assumption that the agreements, though relatively new in form, are not novel in substance. In other words, the premise of the legal analysis was that the essential elements of a preconception arrangement have already received statutory and common law treatment, which would probably render the agreements void and unenforceable.

This assumption is not universally shared. Some commentators argue that preconception agreements are unique, cannot be analogized to aspects of family law, and, when factually described, are more properly the subject of contract law.¹ Such arguments shall be considered below in Part 4. In this part, we focus on the "factual" premise of these arguments. The description of the practice on which these arguments rely will be called the "common depiction" of preconception arrangements. This part aims to delineate this common depiction and then to demonstrate that it is incomplete and misleading.

The Pervasiveness of the Common Depiction and the Case for Further Inquiry

Preconception arrangements are almost uniformly described in the press and other media as a response to the plight of involuntarily infertile, childless, but otherwise happily married couples, who wish to love and rear a child but cannot have one themselves or find one to adopt. This description of the purpose of the practice is almost universally assumed: it is presupposed in brokers' promotional literature,² news stories,³ and television talk shows;⁴ and it is the premise of debate and commentary in proposed statutes,⁵ law reform commission reports,⁶ law review articles,⁷ medical journals,⁸ and books.⁹ The practice is commonly believed to be a solution to which married, childless couples are driven in order to have a child in the face of impaired fecundity and a dramatic decline in the number of children available for adoption. The practice is described as the answer to their impassioned plea, "We just want a child to raise."¹⁰

As an emotional appeal, this depiction invites a positive response — particularly when this poignantly presented demand is met by a supply of women who are described¹¹ and who describe themselves¹² as able, willing, and indeed eager to carry, deliver, and surrender a child to alleviate the suffering of strangers. And upon surrender, the women are described as wanting "nothing further to do with the child."¹³

This is the common depiction of demand and supply, and on this are based most arguments for the practice of preconception arrangements. Before one can consider the strength of those arguments, however, their premises must be evaluated.

The validity of the common depiction cannot be rigorously tested by using social science studies for, as discussed in Part I, there are no comprehensive long-term studies of the practice, its participants, and its outcomes, and some short-term studies have been received with reservation.¹⁴ Notwithstanding the absence of definitive long-term studies, it is essential that arguments for the adoption of a particular legislative policy be based on the fullest possible understanding of the practice; the evidence that is available, even though less than ideal, must be evaluated. This is especially so given that the much-publicized *Baby M* case put the public on notice that the practice is not limited to infertile couples who receive a baby from a willing woman in a manner that is beneficial, or at least not harmful, to all concerned.¹⁵

The lack of social science data prevents us from knowing just how often the common picture inadequately describes the practice,¹⁶ yet it is possible to compare the common depiction to individual accounts of actual participation by participants themselves and by commentators. These accounts are available in a wide variety of publications. Because they have not been elicited in a systematic way, they probably do not accurately reflect the number of persons who experience a particular motivation or effect. But the accounts do illustrate the range of experience with the practice and demonstrate clearly that the common depiction is incomplete.

Using these accounts, this part shows that the common depiction incompletely describes demand and supply in these arrangements; it takes no account of the interests of third parties in promoting the practice and a misleading depiction of the practice; and it minimizes or disregards the harmful and potentially harmful effects of the practice on those affected by it.

Analysis of Demand

A More Complete Description of Commissioners' Characteristics

The common picture of demand in preconception agreements is that there exist involuntarily infertile, childless couples who are likely to remain married and who wish to have a child or to adopt but cannot. They therefore turn, as a last resort, to preconception arrangements so that they might fulfil the desire simply "to have a baby to hold and to love." This picture of demand in the "surrogate motherhood" industry is both incomplete and misleading.

In the first instance, the commissioners might be fertile. At least one commissioning woman conceived when the carrying woman did, so that the commissioners received two children at the end of the pregnancies.¹⁷ If, however, the commissioning woman is infertile, the condition might have been voluntarily induced. For example, Patricia Foster, who relinquished a boy to Mr. Stein and his wife, stated that Mrs. Stein had undergone a tubal ligation after giving birth to three children in an earlier marriage. Although Mrs. Stein's infertility was voluntary and doubtless known to Mr. Stein when they married, he apparently wanted his genetically related child.¹⁸

Secondly, it is not always the case that the couple are infertile in the sense they are unable during their reproductive years to carry a child to term. They might be fertile but unwilling to initiate a pregnancy because of the possibility of harm. For example, Betsy Stern did not attempt to become pregnant as she had a mild form of multiple sclerosis and the relevant literature showed risk that the disease could be exacerbated by pregnancy.¹⁹ A couple might also be concerned about passing on a genetic disorder. For example, Daniel Shapiro entered into a preconception arrangement with a 23-year-old woman because his 40-year-old wife had "decided long ago that she would ... not bear children" for fear of passing on a neurological disease. A commissioning couple might have had children but are no longer fertile simply because the woman's reproductive years have ended. For example, Bill and Betty Meadows had raised two children, a grown son and a daughter (who had been killed in a car accident). When they were each 47 years of age and Betty Meadows had reached menopause, they hired two women to give birth to children for surrender to the Meadows couple. Consequently, at age 50, they have a girl aged two and a boy aged one.²⁰

The data show that commissioning couples are not always childless. Sometimes they have raised children who are in every sense their own,²¹

and sometimes they already have children in their home, as had both the Steins²² and an "immensely likable" couple whose situation was, according to Noel Keane, "desperate": although "Bridget" and "Bill" were raising three children of Bridget's first marriage, Bill "wanted a child of his own."²³ Sometimes the couple have adopted a child together and also hire a woman to give birth to surrender another child to them. Elizabeth Kane, the first carrying woman to receive public attention,²⁴ explained that she had agreed to enter a preconception arrangement because "I had always felt ... an empathy for women with empty arms."²⁵ But the couple receiving the child did not have "empty arms"; they had a three-year-old adopted son. The husband explained that another adoption would have been difficult and "we wanted, if possible, to have a child that was biologically related to me."²⁶ Similarly, Alice Baker twice gave birth to children for commissioning couples who already had an adopted child in their homes.²⁷ There are also instances where men who have fathered children of whom they do not have custody hire women to relinquish children to them.²⁸

The picture of commissioners as always involuntarily infertile and childless is therefore inaccurate. So too is the notion that they are always couples who are married. In an anonymous case, the commissioning man and his girlfriend were not married. Both in their late 40s, they planned to marry once they chose a carrying woman, so that they would "legally be a family when the child is born."²⁹ Commissioning couples who are married do not always remain so. At least four couples have divorced either before or after the birth of the commissioned child. In one case, the commissioners "divorced after the start of the pregnancy and successfully pressed the surrogate to abort."³⁰ In a second case, the commissioner, Alexander Malahoff, commissioned a child to be borne by Judy Stiver "to hold his rocky marriage together," but when the child was born "his marriage was even more rocky."³¹ For reasons to be described below,³² they did not accept the child, who remained with its mother. Two other couples divorced after having the child in their home. Six months after the birth of their commissioned child, Robert Moschetta, age 35, of Los Angeles, left his 51-year-old wife [and took the little girl with him].³³ In the case of Beverly Seymour and Richard Reams, a separation occurred when the commissioned child had been living in their Ohio home for four years.³⁴

Nor is it always the case that there is even a couple commissioning the child. At least ten single men have commissioned the birth of a child.³⁵ Keane describes one who was a 30-year-old student and scriptwriter who "decided he was ready to start a family, but ... he was not yet ready to get romantically involved with a woman." As Keane reported, "Joseph" explained his reasons thus:

This is a very cold and calculated decision, to have a child. I want to have one now — at thirty ... Unfortunately, I'm not ready to settle down with a woman yet and may not be for five or ten years. Why should I wait?³⁶

Therefore, it is clear that the common description of the people who commission children is incomplete. It is not always the case that commissioners are members of a couple or that they are happily married, married, childless, infertile, or involuntarily infertile. Yet the premise of most arguments in favour of the practice is that it alleviates a medical problem: that of involuntarily infertile, childless, otherwise happily married couples.

Why are we presented with this incomplete and misleading picture of commissioners' characteristics? According to a broker, William Handel, the founder of the Center for Surrogate Parenting, Inc. of Beverly Hills, California:

I think that simply for political and P.R. reasons, you've got to play it very conservatively and very safe. It's difficult to take potshots at someone who's doing this for a married couple who cannot have children. But it's easy to criticize someone who's doing it for a gay single male.³⁷

The commonly presented picture has emotional, and therefore politically persuasive, value. By focussing exclusively on the sector of demand that might be most appealing to conservative public opinion, the common picture is designed to suggest that what is in focus represents the full range of commissioners' relevant characteristics.

A More Complete Description of Commissioners' Desires

Not only is the depiction of commissioners' characteristics often inaccurate, so too is the presentation of their desires. What some commissioners seek in a preconception arrangement is more than to have a child to rear; for some commissioners, not just any child will do. For example, there are children to love and rear available for adoption, but they have health problems, or are older or handicapped, or are not Caucasian.³⁸ Two brokers explained the desires of their clients for healthy white infants: Dr. Michael Birnbaum of Surrogate Mothering Ltd. in Philadelphia said,

While there are plenty of babies to adopt, they are not, quote "desirable" ... There are plenty of babies with handicaps, but most couples want a perfect baby if they are going to adopt it, and those kind of babies are hard to come by.³⁹

Harriet Blankfield of the National Center for Surrogate Parenting in Chevy Chase, Maryland, said that commissioning couples did not want older or handicapped children.

When it came to wanting a child — no matter how desperately they wanted a child — they didn't want to take what they would consider second-best ... That may not be a good term but that, verbally, is how they felt emotionally.⁴⁰

These comments from brokers suggest that many commissioners do not wish simply to have a child to rear but desire a particular type of child.

Indeed, an analysis of actual preconception agreements makes it apparent that what is being contracted for is a particular type of child: a healthy child fathered by the commissioning man. It will be recalled that Brophy and Keane's agreements, discussed above in Part 2, each contained a clause that required the commissioning man to accept custody of the child irrespective of its abnormalities, if any.⁴¹ Nevertheless, in each agreement the carrying woman agrees to have an abortion if the fetus she carries is determined to be "physiologically abnormal."⁴² The commissioning man is obliged by the agreement to accept a handicapped child, but he has the power to require testing, in the form of amniocentesis and other genetic investigations, to determine whether the fetus has some defects.⁴³ Even though women in Canada and the United States have a constitutionally protected right to abortion, doubtless considerable pressure could be placed upon a carrying woman who chose not to abort a fetus that had been determined to be abnormal. If she refused to abort the fetus, the commissioners might accept custody of the child at birth but then abandon it. As the majority of the Ontario Law Reform Commission (OLRC) pointed out, the commissioners cannot be forced to rear the child; they may abandon it to be cared for by the state.⁴⁴ Thus, concern for the welfare of the child might not be uppermost in the minds of commissioners presented with a handicapped child.

Consider, for example, the case of Alexander Malahoff, who commissioned Judy Stiver to have a child. She gave birth to a boy who had a small head, microcephaly, which indicated that he might be mentally retarded. Malahoff did not want to raise the boy.⁴⁵ He ordered the doctors not to treat the boy's strep infection, even though the lack of treatment would put the baby at severe risk. If the commonly presented desire of commissioners "simply to have a child to raise" were always accurate, Malahoff would have encouraged the administration of medication to allow the child to live so that he might rear him.

That the child's mother is now rearing him illustrates a second aspect of the commissioners' desires. Some days after Malahoff's order not to treat the child, the participants in the agreement learned (while appearing on the television show "Donahue") that the child had in fact been fathered by Judy Stiver's husband. Malahoff walked away from the situation that his desire to have a child helped to initiate. Clearly, some commissioners want not just a child but a healthy child with the commissioning man's genes.

Indeed, it is an essential condition of the agreement that the child be genetically related to the commissioning man. Brokers are emphatic about this. As Richard Levin, the Louisville broker, said, "We want to make sure that this baby is not the baby of [the carrying woman's] husband. It is important that it be the baby of the adoptive couple ... We only take the real product [sic]."⁴⁶ Both Levin's agreement (drafted by Brophy) and Keane's agreement specifically require the parties and the child to undergo blood tests. Should the tests reveal that the commissioning man is not the father, the agreements terminate. In that event, the carrying woman and

her husband must reimburse the commissioning man for all medical and related expenses, and either care for the child themselves or arrange for its adoption.⁴⁷ Likewise, draft legislative proposals that favour the practice of preconception would make it possible for a commissioning man thus to contract for a particular type of child. The Model Statute of the American Bar Association's Family Law Section specifically states that commissioners are not required to accept a child that is "not as intended, that is, not genetically related to the providers of genetic materials."⁴⁸ The OLRC also recommended that paternity testing be a requirement of the agreement. The implication of the Ontario report is that if the child is not "in fact the product [sic] of that arrangement," the commissioners need not accept the child.⁴⁹

If the purpose of the arrangements were only to enable the commissioners to have a child to rear "to fill their empty arms" at a time when it is difficult to adopt, the patrilineage of the child would not be relevant. And yet the "correct" patrilineage is not only relevant, but essential. This shows clearly that a genetic link is important to many commissioners (and the drafters of some legislative proposals). For example, one commissioning man said, "I come from a very ... old family ... I have no brothers or sisters, and although my parents didn't pressure us, I wanted to carry on the family genes."⁵⁰ Indeed, the desire to bring a genetically related child into the world can be more important than rearing the child. A wealthy 59-year-old man married to an infertile 61-year-old woman had intended to leave his estate to his closest relatives, his nieces and nephews. But when he learned of preconception arrangements, he saw the practice as an opportunity to leave a direct heir, and he contacted Noel Keane to arrange it.⁵¹ Consequently, writer Deborah Poff argues that "[w]hat seems to be the primary value in these cases is not caring for children but caring for one's own genetic stock."⁵² Clearly, the purpose of some commissioners, and the explicit aim of a preconception agreement involving artificial insemination, is not only to have a child to rear, but also to obtain a healthy child conceived with the commissioning man's sperm.

Some commissioners' requirements are even more specific. Both Mr. Stein and "Joseph" wanted boys.⁵³ Some commissioners want girls. In fact, one commissioning couple was presented with two healthy children fathered by the commissioning man, and yet they were not willing to abide by their agreement to accept the children. The carrying woman, Patty Nowakowski, had given birth to a girl and a boy but the commissioners did not want a boy. According to Nowakowski,

They came over to our house and told us that because of a "medical problem" the wife had, her doctor had advised her that caring for the babies would threaten her life. They wouldn't give us any explanation of this problem. Then the wife said that she was willing to risk her life for a daughter — but not for a son ... The biological father and his wife soon confirmed that they would be putting ... one baby [the boy] up for adoption, and, since I was so upset, they agreed to let me make the arrangements.⁵⁴

Nowakowski surrendered the girl to the commissioners and the boy to an adoption agency but later retrieved the boy and demanded that the commissioners return the girl. "Although [the commissioners] did not want to give up the [girl], they stood almost no chance of winning a lawsuit, especially since it was to turn out that the wife's 'illness' was phony."⁵⁵

Many commissioners of children, brokers, and proponents of preconception arrangements attempt to justify the practice by the argument that it gives children to otherwise childless couples. In reality, it also enables some commissioners to commission a child of a predetermined health, patrilineage, and sex. Thus, the commonly presented picture of demand in surrogacy arrangements is incomplete and misleading. Commissioners are not always involuntarily infertile, childless, married couples likely to remain married, who wish to love and rear a child but who cannot have one themselves or adopt. The commonly presented picture fails comprehensively to represent who the commissioners are and what they want. The purpose of demonstrating that this is so is not to claim that one person's reasons for wanting a child are more legitimate than another's; the point is that arguments in favour of preconception arrangements (to be considered in the next part) are unconvincing unless they are based on a complete and accurate description of demand.

Analysis of Supply

Just as the commonly presented depiction of demand is misleading, so too is that of supply. Carrying women are depicted as being motivated to relieve the commissioners' suffering by freely conceiving, gestating, and delivering a child for them to rear.⁵⁶ In this way, the misleading picture of demand both generates and favourably characterizes supply. Further and independently of demand, the "supply" is described as an aggregate of women who willingly choose to relinquish their children and disassociate themselves from them forever. This description is incomplete and misleading for several reasons, including that it suggests carrying women exercise only one important choice when in fact they exercise at least two; it does not attend to the problematic aspects of the contexts in which the choices are made; and it incorrectly suggests that the carrying women wish to have nothing to do with the children after they relinquish them. These reasons are discussed in more depth in the following pages.

The Effect of the Common Picture of Demand in Generating and Characterizing Supply

Clearly, the common picture of demand generates supply. According to one commentator,

Surrogate mothers are not true supply-siders, since they do not let supply create its own demands; they fill a need already there. Infertile people want babies, and surrogate mothers produce them. They understand the needs of others and fill them.⁵⁷

In focussing attention on the plight of the childless and infertile, the common picture of demand deftly elicits an empathetic response from

would-be carrying women. As a broker's staff member said, carrying women cannot imagine life without children because motherhood is central to their lives; they feel sorry for the infertile couples who, they assume, are childless.⁵⁸ To generate a supply of women who will sign an agreement to relinquish their children at birth, brokers make appeals through the media for compassionate women who will "give the gift of life" to a childless, infertile couple.⁵⁹ Brokers search for women who are compassionate rather than intelligent.⁶⁰ They want someone who will put another's needs before her own; hence, they recruit in publications such as *Nurses Week*, appealing to

a population [that the Center for Surrogate Parenting] encourages as prime candidates for the most delicate of jobs ... [Nurses are ideal because they are] compassionate, empathetic women who are responsible and have the desire to make a difference in someone's life.⁶¹

The difference these women make to the lives of the commissioners is not always what they think. That the misleading nature of the common depiction of commissioners' characteristics and desires might be essential to its power to generate supply is suggested by the outrage some carrying women have expressed when they discover they have been misled. For example, Patricia Foster criticized Noel Keane and his colleagues for deceiving her about the commissioners' true situation. "They play upon your emotions when they talk about the poor infertile couple who have tried everything. We were told that we were their last hope and that this was the most unselfish thing a woman could do."⁶² Foster claims that Keane was not "up front with [her] about a lot of things." She did not know that the commissioning woman had given birth to and was rearing her three children from an earlier marriage and that she had deliberately sought a tubal ligation to render herself infertile.⁶³ Similarly, Elizabeth Kane argues that she did not know that the commissioning man wanted not simply a child to rear, but his genetically related child.⁶⁴ Likewise, alleged deception caused a North Carolina woman to grieve "silently for several years upon learning her baby broker ... had lied to her. The contracting couple was not a wealthy young couple from Maryland but instead a man from Israel."⁶⁵

In addition to eliciting the participation of carrying women, the commonly presented portrayal of demand has a second effect on supply: it characterizes carrying women as "the sisters of mercy" of the commissioners and, in particular, of the commissioning woman. In willingly sacrificing themselves and their bodies to fill the "empty, aching arms of the infertile wife," carrying women become, through the power of the common portrayal of demand, altruistic angels. According to a broker's staff member, carrying women are

the most lovely, healthy, functional group of women I had ever seen ... empathetic, sensitive women who emphasized the importance of motherhood in their own lives ... Being a surrogate mother is a way of making what they feel is a dramatic contribution to the world, to

alleviate a problem — childlessness — with which they can sympathize. And it's a contribution they can make while still remaining within the surroundings of their own family.⁶⁶

With this "special" image of carrying women, brokers encourage other women to participate in preconception arrangements. Brokers recruit in such articles as "Searching for a Very Special Woman," published in *McCall's*,⁶⁷ and in such videos as *A Special Lady*, available at no charge from Noel Keane and shown "to teenage girls in high schools," where young girls especially are ripe for this kind of "specialness."⁶⁸

Yet this presentation of carrying women as "special" tends to unravel when it is tested against the actual facts of a commercial preconception arrangement. If the carrying women are aptly described as "altruistic angels," why are they paid? The broker's reply is that the women are motivated not by the money but by the empathy they feel. According to Keane, "Their motivation is to help somebody, though the money would be helpful."⁶⁹ Broker Bill Handel denies that women do it for the money:

No it certainly isn't the money. Ten thousand dollars that's paid to a surrogate doesn't even begin to compensate two extraordinary years of work. It is pride in their ability to create a child ... they're extraordinarily proud of the fact that they have a family and it's a humanitarian gesture.⁷⁰

Despite the brokers' denials that the payment of money is essential to generate a supply of carrying women, the fact is that the brokers would not be in business if they could not pay carrying women. Keane himself acknowledged that in 1980 during the time when he dealt exclusively with volunteers, only one woman a year offered to perform the humanitarian gesture.⁷¹ He said then, "If we could pay women \$5 000 to \$10 000, everyone could have a surrogate."⁷² Once he did commence payment, the number of carrying women increased to 20 in each of the first two years he started to pay.⁷³

A second difficulty with the characterization of carrying women as special, selfless, and altruistic is that their "act of generosity" consists of exchanging their own baby for cash. If they are in fact family-oriented women, "your normal, middle-American, other-centered Mom,"⁷⁴ as a broker's staff member, Hilary Hanafin, claims, why do they relinquish their children to strangers? To this, the brokers also have an answer. The child is not the carrying woman's baby at all but the commissioners' baby. According to Keane, "[The carrying woman] knows that before she becomes pregnant, she's going to carry this person's child who cannot carry her own baby."⁷⁵

Thus, the commissioned act becomes not the surrender of a child but rather the utilization of a female body. As Handel argues, "If there is a uterus available, let us use one."⁷⁶ By denying the carrying woman's maternity with the very term "surrogate mother," and by constantly reinforcing the fact that the sperm originated from the commissioning man,

the brokers suggest that their "special lady" has little claim to her child. As Keane argues, "What you have to keep in mind always is that this baby is always returned to its biological father."⁷⁷

A final inconsistency in the characterization of carrying women as altruistically helping a childless, infertile couple, and in particular the commissioning woman, is that the "service" a carrying woman provides most unambiguously benefits the commissioning man rather than the commissioning woman, if any. If the commissioning man is single or partnered by a male, there is obviously no commissioning woman to be helped. Even when the commissioners are married, childless, and incapable of having a child, the commissioning woman might well be ambivalent about the agreement. For what actually takes place when the pregnancy is initiated by insemination (as are the vast majority of cases) is that a man conceives a child by a woman who is not his wife and then expects his wife to rear the child. That a commissioning woman might be ambivalent about the proposed arrangement is revealed in the following account:

A lady in Wisconsin recently testified before state legislators. She burst into tears at the end of otherwise glowing testimony when a Senator asked her about HER feelings. She sobbed hysterically, "The experience of looking through a catalog with my husband to find him a surrogate was so humiliating."⁷⁸

Keane himself reports how injurious to his wife can be a man's quest for a child through a preconception arrangement:

The man was obsessed with having a child, but his wife, who was rather sickly, seemed to care less, although she said all the proper things. The woman had diabetes and kidney problems and it was a full-time job for her to take care of herself. Nevertheless, her husband insisted that they wanted to find a surrogate mother. About two weeks [later, the] wife just up and left to live with a former boyfriend in Florida. She left a note saying that she could not stand the pressure being put on her to have a child.⁷⁹

The preconception arrangement can end a marriage in other ways, too. According to Keane,

I heard from a hysterical wife. Seems like the husband and surrogate mother went to a motel to attempt the insemination and decided, what the hell, why not try it the good old-fashioned way? They liked it so well they ran off with each other.⁸⁰

Although the poignant presentation of demand depicts carrying women as altruistic, family-centred women who are helping infertile childless couples, and in particular the commissioning woman, the facts of the arrangements suggest otherwise. The "altruism" is rewarded by cash; the "family-centred woman" relinquishes one of her children who is also her other children's half-sibling and her parents' grandchild; and her "generosity" is not always desired by a commissioning woman. This is not

to deny that some, or indeed most, carrying women are compassionate and empathetic. The point is to make clear that the facts of the arrangement might have been used to paint a much darker picture, for example, of a new form of prostitute who sells her body to provide a single man with a child, or a married man with what he is missing at home — childbearing ability. But the power of the incomplete and misleading picture of demand is such that carrying women have become, in the eyes of the public, "special ladies." Among the many effects of this portrayal is to marginalize those women who cannot easily be described as "altruistic angels,"⁸¹ and arguably to silence those who regret having relinquished their children and do not feel "special" at all.⁸²

A More Complete Picture of Supply

Independently of demand, the common portrayal of supply is incomplete and misleading in at least three more ways. First, it suggests that carrying women freely choose to participate in a preconception arrangement, to surrender their children, and to disassociate themselves from them forever. But not all women freely participate, and the context in which women *do* choose to participate is often problematic. Secondly, the common depiction collapses the distinction between choosing to participate in a preconception arrangement and choosing to relinquish the resulting child. Thirdly, it incorrectly depicts women as intending to disassociate themselves from their relinquished child forever.

The description that each carrying woman "intentionally conceives, carries, and bears a child to be raised by someone else"⁸³ is not accurate: not all women freely choose to participate in the arrangement, and of those who do choose, the choice might be made under constrained circumstances. At least two women were forced to enter into preconception arrangements: one was an illegal alien in the United States brought there from Mexico by her cousin;⁸⁴ the other was a 12-year-old girl repeatedly raped by her stepfather so that she would conceive a child whom he and his wife could rear.⁸⁵

Apart from cases of alleged overt coercion, there are many cases in which the "choice" to participate in a preconception arrangement is exercised under constraint. For example, some women agree to enter into a preconception arrangement with their employers. One such case was revealed by Allan Leal in his dissenting opinion in the OLRC report. A carrying woman who received no payment for her baby and who presented herself before the OLRC was asked why she had participated in a preconception arrangement. She replied that "she had done it to help her male superior at the office."⁸⁶ According to Leal, "One need not be a total cynic ... to see the fatal flaw in this arrangement. Quite obviously, surrogate agreements have the potential for exploitation, even in circumstances where direct payments are not being made."⁸⁷

A second case of a woman allegedly entering into a preconception arrangement at the instance of her employer is that of "Amelia," a 28-year-

old Argentinean woman who cooked and cleaned in a Buenos Aires health clinic. There, she was approached by one of the physicians who, acting as a broker, solicited her participation in a preconception arrangement.⁸⁸ Her husband was unemployed and encouraged her to participate in the arrangement in return for the promised payment of the equivalent of \$2 400 (U.S.), which would solve the most pressing economic needs of their family of three children.⁸⁹

Beyond the employment context, the fact that many carrying women receive payment for participating in a preconception arrangement raises the possibility that some are in strained financial circumstances and therefore find the money irresistible. That the promise of payment can be coercive is conceded even by those who stand to gain from the practice. For example, Matthew Myers, a lawyer who acts for Surrogate Motherhood Inc. of Maryland, said,

If the money we are going to pay them is the difference between their survival and nonsurvival, the ability to feed their families or not, I think there are some potentially strong questions as to how free the choice really is. They are in a position where they are desperate for money, and in that circumstance there is at least an argument that they haven't entered into it as freely as possible. There is also an argument that we are using and abusing their poverty to take advantage of their bodies. We don't want surrogacy to be an upper class use of lower class women to produce their offspring.⁹⁰

Sensitive to this concern, proponents of the practice paint a picture of supply as consisting primarily of middle-class women who wish to help middle-class commissioners.⁹¹ They minimize the potential coercive effects of payment on prospective carrying women. According to Lori B. Andrews, a carrying woman's choice to enter into such arrangements is not compromised by the promise of financial reward:

In the actual surrogacy arrangements, the \$10 000 was not as potent a lure as surrogacy opponents made it seem. The money was not given in a lump sum at the time the woman joined [Keane's] program, but rather (as in other forms of employment) was spread out over her service in the program. Since it might take months for the woman to be matched with a couple, then more months of artificial inseminations for her to conceive, the \$10 000 might be her payment for two years' work, with the bulk of the amount coming at the end. "Surrogacy is not for poor women," says surrogate Jan Sutton. The surrogates need to have enough money themselves to cover out-of-pocket expenses until they can be reimbursed.⁹²

This argument, however, does not demonstrate that poor women are not exploited by paid preconception arrangements or are not persuaded by the payment; it merely implies that poor women would be unwise to participate.

A similarly weak argument is made by the president of the Pacific Coast Obstetrical and Gynecological Society. Dr. Eugene C. Sandberg extols the practice and denies that it raises concerns about the abuse of one socioeconomic class by another.

As for the potential to exploit the poor by employing them to accept the risk and inconvenience of pregnancy for the rich, one should recognize that the poor are unlikely to be chosen for this task. Poor women commonly have been condemned throughout life to marginal health [and] chronically inadequate nutrition. They ... [have] an elevated incidence of infant morbidity and mortality because of their equally elevated incidence of premature delivery, intrauterine growth retardation, and other fetus-endangering abnormalities of pregnancy. These are not the stably healthy and reproductively accomplished women who would be sought and accepted in the quest for such a highly regarded prize.⁹³

Like Andrews, Sandberg fails to prove that there is no class exploitation. Sandberg succeeds only in suggesting that prospective commissioners would be unwise to hire poor women because such women are of insufficient quality to produce the "highly regarded prize."

To attempt to prove that the practice does not exploit the socioeconomically disadvantaged, proponents also quote an articulate carrying woman, Donna Regan:

I'm not poor, and I'm certainly not stupid. I'm not in any manner ignorant or uneducated, so there is really no basis for argument there. None of the surrogates I have ever met have been stupid or uneducated.⁹⁴

Despite the arguments offered by proponents and the denial of a carrying woman, the question remains whether many or even some carrying women of low socioeconomic status are induced by the promise of payment to enter a preconception arrangement for the benefit of commissioners of higher status. The evidence suggests that the picture of a middle-class supply painted by proponents is incomplete and misleading.

As Keane himself admits, "Rich women ... are not likely to become surrogate mothers."⁹⁵ As has been discussed in Part 1, what few data are available indicate that carrying women tend to come from a lower socioeconomic class than the commissioners. The only published comparative research revealed that, as a group, the commissioning couples had significantly higher levels of income and educational attainment than had the carrying women.⁹⁶

It would appear from these data that the participants in the *Baby M* preconception arrangement were not atypical. According to one commentator writing between the time of the trial and appellate court decisions,

The Sterns [the commissioners] have a joint income of more than \$90 000 a year. Mary Beth Whitehead [the carrying woman] is married to a sanitation worker with a salary of \$28 000 a year. The Sterns are highly educated professionals. Mary Beth Whitehead, sixth of eight children of a schoolteacher and a beautician, left high school before graduation, married at age sixteen, and had two children before her nineteenth birthday.⁹⁷

Other accounts of carrying women suggest that the promise of payment does induce women from a low socioeconomic class to enter into

preconception arrangements. In the first case involving Canadian commissioners to attract media attention, the carrying woman was a 20-year-old from Florida. She and her husband had 17-month-old twins for whom they were finding it difficult to provide. According to the *Toronto Star*,

[she] was frank about why she offered herself as a \$10,000 hired womb to a Scarborough couple desperate for a child: "We needed the money badly. My husband is a student and works two jobs nights and weekends to keep us going. I work on call as a cocktail waitress. We earn less than \$10,000. And some days we only see each other for 20 minutes."⁹⁸

Similarly, in Australia, among the first women to apply to participate as a carrying woman was "a 23-year-old whose husband was terminally ill and who said that she urgently needed the \$10 000 to provide some security for her child."⁹⁹

Some other women who appear motivated primarily by the money are single mothers. One woman in New England gave birth to her first child when she was 17. Because she could not provide a home for the baby, she put her in foster care and then entered into two preconception arrangements. She gave birth again at the ages of 19 and 21. With the fees earned by surrendering the second and third babies, she purchased a mobile home and brought her three-year-old daughter home. She said that she would enter yet another preconception arrangement if the money would help "bring consistency into my three-year-old's life." But because she found a steady job as a day-care worker, she said she would not do it a third time.¹⁰⁰

A single mother in Staffordshire, England, also agreed to enter a preconception arrangement to provide for her child, a seven-year-old boy. According to Sir John Arnold, Mrs. P. initially entered into the arrangement because she was entirely dependent on social security; she was "impecunious and hard put to provide satisfactorily for [her son]."¹⁰¹ The commissioners in that case exhibited a "far larger degree of affluence than [could] be demonstrated by Mrs. P. ... [and] the intellectual quality of the environment of [the commissioners'] home [was] greater than the corresponding features in the home of Mrs. P."¹⁰²

Thus, despite the middle-class picture of supply painted by proponents of the practice of preconception arrangements, the available statistical data and some anecdotal accounts indicate that carrying women tend to be of a lower socioeconomic class than the commissioners, and that the promised payment has power to induce their participation.

For at least one brokerage agency, the very fact of a carrying woman's impecuniosity is precisely the reason that she is suitable. Dr. Howard Adelman, a psychologist who screens prospective carrying women for Surrogate Motherhood Ltd. of Philadelphia, told *Ob/Gyn News*,

I believe candidates with an element of financial need are the safest. If a woman is on unemployment and has children to care for, she is not likely to change her mind and want to keep the baby she is being paid to have for somebody else.¹⁰³

To avoid the charge that carrying women do not freely choose to enter a preconception arrangement, proponents paint a picture of supply as consisting of middle-class women helping people much like themselves. Yet the only research that has compared carrying women to commissioners reveals that the practice of preconception arrangements tends to move children from the homes of the less advantaged to those of the more advantaged. Economic hardship can, in fact, induce participation, and it compromises choice. Thus, the practice encourages some mothers to provide for their children by trading another child for cash.

Apart from the problematic contexts created by employment or financial need, the decision to enter a preconception arrangement can be made in circumstances that are problematic for psychological reasons. As discussed in Part 1, the only study of the motivations of carrying women was conducted by Dr. Philip Parker, a proponent of the practice¹⁰⁴ who claimed that personal and psychological factors might be significant in prompting participation.¹⁰⁵

On the basis of data obtained from the first 125 women he interviewed, Parker identified three complementary factors that motivated participation in a preconception arrangement: (1) the perceived desire and need for money; (2) the perceived degree of enjoyment and desire to be pregnant; and (3) the perceived notion that the advantages of relinquishment outweighed the disadvantages. (As has just been discussed, the first motivation, which is financial, is problematic.) In a second study reported in 1984, Parker revealed that the last two motivations often arose in circumstances that were problematic for psychological reasons.¹⁰⁶ The following anecdotal evidence supports this hypothesis.

According to Parker, most of the women studied enjoyed being pregnant and enjoyed the special attention they received by being pregnant. Although Parker does not analyze this motivation, it merits discussion. An unusually great need for attention and affection might be met by commissioners and brokers, if any, during the life of the agreement. Because the need is met, a carrying woman might fulfil the agreement. Yet, the need for attention and an ongoing relationship might survive the relationship and indeed increase because of it, as the agreement itself entails that contact between the parties should cease once the child is surrendered. A carrying woman's need for attention can thus be a peculiar vulnerability,¹⁰⁷ which might only temporarily be recognized and attended to by commissioners and the broker. They might meet her needs so that she will conceive and deliver the child, but not afterward.

If the need for attention is not met prior to conception, a carrying woman might decide to withdraw from participation. Noel Keane quotes a

woman who, after miscarrying a fetus fathered by a commissioning man, ultimately decided to become pregnant by another commissioner because he and his partner exhibited more concern for her:

I was surprised at how powerful my feelings were. I mean, I had been saying to myself all along, "it's their baby. It's Judy's baby. I am only carrying it for them." But when I lost the baby, I was depressed for weeks. That was the beginning of the end for me and the dentist and his wife. I guess I expected them to send me a flower or a card or at least ask, "Donna, how are you?" But it was like they didn't give a damn. I tried twice again to get pregnant for them, but my heart wasn't in it. After the second time when the insemination didn't take, I told them, "I don't want to do this anymore" ... I just walked away. "Then, through [Noel Keane] I met Thomas and Cindy Sue. They care about me, and it shows. I really want to give them a baby."¹⁰⁸

At least one broker, Bill Handel, recognizes this need for attention and concern and its power to enhance or deny a particular carrying woman's participation. In compulsory group therapy sessions at his Center for Surrogate Parenting, carrying women and prospective carrying women express their feelings, which the group leader (employed by the broker) can then act on. Consider, for example, the account of one pregnant woman who felt the commissioners were insufficiently attentive:

Kate, who [was] four months pregnant, had been feeling a bit neglected by her couple, but once Donna, the group leader, called and encouraged them, the husband and wife have become far more attentive. "A letter, two phone calls and a basket of fruit — all in one week," Kate [said]. "What more could you want?"¹⁰⁹

If the attention is not forthcoming once the woman is pregnant, the carrying woman can become so bitterly disappointed with the agreement as to suggest that her principal motive in participating was to receive special attention and concern.¹¹⁰

The intensity of the relationship between the carrying woman, the commissioners, and the broker, if any, might be such that a carrying woman could expect that it would continue after the pregnancy even though the commissioners have no intention of continuing contact once they have the child.¹¹¹

One carrying woman, Nancy Barrass, understood that she would continue to see the commissioners and the child after relinquishment. On the television show "Donahue," she described why she was attempting to regain custody of the child.

Donahue: Your verbal understanding [was] that you would be ... like an auntie?

Nancy Barrass: Yes. That was something we agreed upon. I read about [the couple] in the paper three years ago, and they were looking for a surrogate mother who wanted to be in an auntie relationship and their children would be a cousin to that child. And that is the reason I sought out this couple. It took me ten months to find this particular couple ...

Donahue: ... But we certainly understand their interest in not having you in an almost terrorizing way, knock on the door at your leisure, you can't raise a child that way.

Nancy Barrass: Then they should have never had me into their home for two years. Their parents, their relatives, their friends, their neighbors, their co-workers have all met me, all had me into their homes. I was in their life on a weekly basis for two years until I gave birth ... they did lead me to believe that we would continue our weekly relationship. Why did they see me on a weekly basis and then all of a sudden drop the relationship?¹¹²

The need for attention from, and an enduring relationship with, the commissioners and the broker can be problematic, for while it probably varies in intensity among women and during the course of the agreement and afterward, it is unlikely to continue to be met once the agreement has ended and the child has been surrendered. Once carrying women have provided the "gestational services," they can find they are no longer deemed special. Two writers report that

Some women donors mention as a benefit the attention they receive from prestigious people. They are courted and cared for — if only temporarily — by physicians and lawyers, and may even appear on television. This need for attention may ultimately backfire. [Broker's] staff remark that some women return regularly for favors and advice, expecting to receive continued support. They do not always get what they are looking for and end up feeling angry and disappointed.¹¹³

That they might be well treated while they are attempting to conceive or are pregnant, but not afterward, perhaps reflects the view of commissioners and brokers that the carrying women are producers of a desired child and useful only up to that point. If carrying women are peculiarly vulnerable to the need for attention and affection, they might also be peculiarly vulnerable to feeling hurt when the arrangement and thus the attention and the relationship cease. The Staffordshire single mother of a seven-year-old revealed this vulnerability in a letter written to the commissioner after the births: "What I ask you to remember, is that after all I have done for you I am still a loving, caring person who needs to be loved. I have so much love to give, but never get anything in return but hurt."¹¹⁴

The fact that a carrying woman received special attention and affection might be revealed to have been a strategy to ensure fulfilment of the agreement rather than the expression of genuine concern for her. According to the mother of a carrying woman who died because of complications of the commissioned pregnancy, neither the commissioners nor the broker even telephoned or sent a card or flowers.¹¹⁵

Thus, the desire to receive special attention, which Parker claims is a motivation to enter a preconception arrangement, can be problematic. If it is in fact a desire to receive affection and recognition of one's unique personhood, it is unlikely that a preconception arrangement will truly

satisfy that desire. Such an arrangement contemplates the production of a child by a woman whose essential value to the commissioners and the brokers lies in her reproductive capacities. If she fails to exercise those capacities, she might be of no value. If she succeeds in becoming pregnant and surrenders the child, her value to them might well diminish, even though her need to feel valued might have increased.

The last motivation identified by Parker, if accurate, also suggests that the decision to enter a preconception arrangement can be made in a problematic psychological context. Parker claims that the carrying women in his studies were motivated to participate in a preconception arrangement by the perceived advantages of relinquishing the child. According to Parker, this factor includes both the experience of "repeating a prior voluntary loss of a fetus by abortion or a baby by relinquishment" and of "giving a gift of a baby to an infertile couple."¹¹⁶

In Parker's sample of 30 women, 10 had voluntarily lost a fetus or a child either by abortion (7 percent) or by relinquishing a child for adoption (3 percent).¹¹⁷ It is not clear, however, whether these abortion and relinquishment rates differ from those found in the general population. Nonetheless, Parker claims that

the experience of relinquishing the baby sometimes appeared to help the surrogate deal with prior unresolved voluntary losses of a fetus or child — either their own loss or that of a close family member (mother) with whom she identified.¹¹⁸

There is anecdotal evidence that some carrying women have had abortions in the past and enter a preconception arrangement as a consequence. In an article in *Woman's Own*, prospective commissioners described the motivations of a prospective carrying woman thus: "She explained that she'd had an abortion when she was much younger, and she wanted to repay it with another life."¹¹⁹ Similarly, another woman said, "I had an abortion several years ago which still troubled me. It was traumatic and I couldn't get it out of my mind. I had wanted another child, but it was impossible for us economically to raise another one. I couldn't replace the aborted child, but I wanted to compensate for it in some way."¹²⁰ Another woman surrendered four children pursuant to preconception arrangements after she had given up two children for adoption:

When I was sixteen, I'd become pregnant and had married my high school sweetheart. Four years later, my marriage was over and I was alone with a three-year-old and a one-year-old, and no way to support them. I had no skills; I'd never held a job. My ex-husband had joined a motorcycle gang, and I couldn't count on him for any kind of financial support, nor could my parents afford to help. I was desperate ... finally, I made the most painful decision of my life — I would give my children up for adoption.¹²¹

Eight years later she met her second husband with whom she immediately had a child. She wanted to have another child but "we couldn't support a

bigger family on his income as a construction worker, and I was determined to stay at home full time with my son."¹²² She claims to have fulfilled that "yearning" to be pregnant by carrying and surrendering four more children.

Thus, there is some anecdotal support for Parker's theory that a prior loss of a fetus or child is causally connected to some women's decision to enter a preconception arrangement. Yet Parker does not make clear how the repetition of the loss actually benefits a woman. If the first loss troubles a woman, it might be that the second or subsequent one will too. Indeed, Parker himself acknowledges that some carrying women "consciously expressed a desire to have their own replacement child [after relinquishing the commissioned child] to help deal with the feelings of sadness and loss."¹²³ If a carrying woman benefits by a "replacement child," arguably what she needed to overcome the first loss was a child, not a second loss from which she would also need to recover. Despite Parker's implication that preconception arrangements are good for carrying women, they are of questionable therapeutic benefit to women suffering from a previous abortion or relinquishment.¹²⁴ What is more, the fact that the woman has suffered a loss by abortion or relinquishment might make her vulnerable to the need to have another child; this might be a vulnerability upon which brokers capitalize.

This last motivation that Parker identifies — the perceived advantages of participation in a preconception arrangement — has a second factor: the desire to give a gift to an infertile couple. Parker claims that

Many pregnant surrogates found that their experience gratified their wish to give the gift of a baby to a needy couple. Thus, many experienced a sense of accomplishment of doing something worthwhile and valuable.¹²⁵

If Parker is correct in his view that women are motivated to enter a preconception arrangement to give a gift, that motivation also arises in a problematic context. If the child is a gift, how can the woman receive payment for the child? According to proponents Frank and Vogel, the money payment is a gift. "The gift of the couple, their investment, is the money; the surrogate's gift is a baby."¹²⁶ Thus, even though paid arrangements consist of trading a child for cash, some advocates of the practice attempt to alter the ordinary meaning of the term "gift" by claiming that the money transaction is an exchange of gifts.

The carrying and surrendering of the "gift" are also accompanied by the denial that the child is the carrying woman's child. Indeed, Keane has promoted this view from the outset, as is obvious in his 1981 advertisement:

COUPLE UNABLE TO HAVE CHILD WILLING TO PAY A \$10 000 FEE AND EXPENSES TO WOMAN TO CARRY THEIR CHILD. CONCEPTION TO BE BY ARTIFICIAL INSEMINATION. PLEASE CONTACT: NOEL P. KEANE, ATTORNEY ...

All responses confidential [emphasis added].¹²⁷

The resulting confusion as to who is the mother of the child can cause regret in a carrying woman when she realizes that the child whom she conceived by artificial insemination and delivered is in every sense *her* child. As Patti Foster lamented, "Noel Keane said it would be their child. It was Michael Stein's child and *my* child."¹²⁸ Yet, according to Parker, denial is significant to the carrying woman as a strategy to deal with the anticipated loss.¹²⁹ One carrying woman has said, "It was important not to think that the baby was mine, otherwise you're living a lie and you're also making it hard for yourself when you know that you've got to hand it over."¹³⁰ By denying their maternity, some carrying women and the brokers claim that the baby whom the carrying woman relinquishes is not really hers.

The complexity of this alleged motivation thus increases. According to Parker, women wish "to give the gift of a baby," yet they receive money for the baby and they deny it is theirs to give. If women are indeed motivated by this desire, it is clearly illogical and irrational.

Thus, the two psychological reasons that Parker identified as motivations for participation in a preconception arrangement can, like the financial motivation, arise in contexts that are problematic. The desire to receive special attention might be a vulnerability on which commissioners and brokers can capitalize until they have achieved their ends. The desire to achieve the benefits of surrendering a child is also problematic, for if the benefits are to overcome a prior loss and to give a gift, it is not clear how enduring another loss is helpful or how one can purport to give a gift while accepting money in exchange and simultaneously denying that the child is one's to give.

In summary, the common depiction of supply suggests that carrying women freely choose to participate in preconception arrangements. This description is incomplete and misleading. Some women do not choose to participate at all, and many of those who do choose, do so in problematic circumstances: in the coercive context of the workplace, because of a need for money, or because of psychological reasons that reveal particular vulnerabilities or that can be described only as illogical or irrational.

A second way in which the common depiction of supply is incomplete and misleading is that by collapsing the distinction between the decision to enter a preconception arrangement and the decision to relinquish the child, it suggests that there is only one significant choice, whereas Parker's study and carrying women's experience suggest there are two.

Parker found that the motivations for entering the agreement and for relinquishing the child are different. Even though money was important in initiating the agreement, "the fee became less important as the pregnancy developed."¹³¹ According to his findings, women surrendered the children not because of the promise of payment but because of "a sense of duty and need to please the [commissioners] by relinquishing a healthy baby for them to parent in a loving and caring way."¹³² In Parker's study, one woman refused to accept the \$10 000 fee once she had established a relationship with the commissioners.

Anecdotal evidence confirms that what motivates participation is not always what motivates relinquishment. For example, a woman who claimed that her pregnancy was agony "often contemplated keeping the baby," once she learned the child was a girl. "Only loyalty to the couple she was working with made her stick to the agreement."¹³³ Likewise, another woman motivated herself to surrender the child by focussing on the commissioners' potential disappointment: "I felt so sorry for them ... How many years they'd tried for something that had come so easy for me. All I could think was *don't let them down.*"¹³⁴ Another woman who "started having doubts" as soon as she was pregnant said that the commissioners were so kind to her that she felt, "I had to go through with it." But she said she would not do it again.¹³⁵

Broker Bill Handel is apparently aware that carrying women can be motivated to relinquish the child by concern for the commissioners. For this reason, his brokerage house encourages commissioners and carrying women to develop a relationship. As staff member Hilary Hanafin said, "It works for us because she cannot imagine hurting this couple whom she knows and likes so much."¹³⁶

The difference in the motivations to enter a preconception arrangement and to relinquish a child suggests that carrying women make two choices, not one: the first to conceive a child for the commissioner, and the second actually to surrender the child. From the perspective of the carrying woman, the distinction can make all the difference. Consider what Mary Beth Whitehead said about the Sterns:

I felt a really big obligation to them, not because of the contract but because of them ... I really started out wanting to do this. It hurt me to know I was going to hurt the Sterns not to give them the baby. But the obligation I felt to my child was stronger.¹³⁷

A third misleading aspect of the common depiction of supply is that it suggests that carrying women wish to step out of the child's life forever. As the OLRC claimed, "She wishes to have nothing further to do with the child."¹³⁸ But even Parker's study discloses that many women do wish to perpetuate in some way the relationship they have with their child.

Most surrogates expressed thoughts of wondering how the baby would fare in the future. Many were interested in being updated periodically either directly by the couple or indirectly by someone else. Some surrogates planned on maintaining a future relationship with the parental couple. Some wished they could maintain such a relationship but were refused by the couple; they often felt angry and unhappy about the enforced exile from the parental couple and their new child.¹³⁹

Anecdotal accounts reveal that many women either have expressed a wish to care for the child if the commissioners could not, or are rearing the child because the commissioners would not. An example of the first is Mrs. P. in the Staffordshire case. She wrote in a letter to the commissioning man,

because you say I can see the babies after the adoption makes things a little easier for me ... I want you to promise that if there are any changes in your life that could leave the babies without you, then you will make sure I get the babies back. I need to know that if the babies are not with you then they will be with me.¹⁴⁰

Stories of women rearing children who were not desired by commissioners have already been related.¹⁴¹ In the Malahoff and Stiver case, Mr. Malahoff refused to accept a child with microcephaly not fathered by him; the Stivers are now rearing the child. Likewise, Patty Nowakowski is rearing her twins, a boy and a girl, because the boy was rejected by the commissioners. These children could have been placed for adoption. It appears that, contrary to the argument that carrying women wish to terminate their relationship with their children at birth, some carrying women *do* wish to maintain a relationship, or, in default of the child's acceptance by the commissioners, will actually rear the baby themselves.

Thus, the common picture of supply as consisting of women who freely choose to participate in a preconception arrangement to surrender their child forever is incomplete and misleading. Although such a description might aptly describe the decision of a sperm donor to surrender sperm, it is insufficiently complex to explain the vastly different situation where a woman agrees to enter a preconception arrangement. Such a course of action might not be chosen; it might be taken in a financially or psychologically problematic context that constrains decision making; it is often perceived to be a decision different from that to relinquish a child, and it does not necessarily entail that the carrying woman wishes to sever her relationship to the child forever.

The Effect of Third Parties' Interests and Activities

The common depiction of the practice of preconception arrangements is misleading in yet another significant way: it is insufficiently broad in scope, for it takes no account of the career interests of third parties in the practice itself. An understanding of the interests and activities of brokers and infertility practitioners is essential to understanding the current practice of preconception arrangements.

Brokers

As described in Part 1, brokers operate publicly in the United States, where there are at least four who often gain media attention: Noel Keane (who has offices in Dearborn, Michigan; New York City; Indianapolis; and in a suburb of San Francisco); Bill Handel of the Center for Surrogate Parenting, Beverly Hills, California; Richard Levin of Surrogate Parenting Associates, Louisville, Kentucky; and Betsy Aigen of the Surrogate Mother Program, New York City. Their fees are substantial. For example, in 1987, Aigen charged \$11 000.¹⁴² In 1989, Keane charged \$11 000¹⁴³ and Handel \$16 600.¹⁴⁴ Although they act as "middlemen," bringing the parties together, they are paid by the commissioners and therefore concentrate on

their interests.¹⁴⁵ Although brokers often claim they are helping infertile couples, they do not act on behalf of infertile couples who cannot afford their services. Preconception arrangements are a business, and a sufficiently wealthy commissioning couple is a market opportunity. As Handel said when he described why he became a broker, "I realized that there was something going on there, 100,000 infertile couples and not enough babies to go around."¹⁴⁶

In this business, babies are products. Consider, for example, how Keane's activities are described in a popular magazine:

By devising elaborate contracts and pulling together a supply of surrogates sufficient to meet the demand, Keane has revolutionized the production of babies just as surely as that earlier son of Dearborn, Henry Ford, revolutionized the production of automobiles.¹⁴⁷

The activities of brokers are those of business people. Brokers attempt to create and legitimize demand and to ensure adequate supply; they engage in damage control when public opinion of their activities begins to fall; they seek publicity and they advertise; they shop for jurisdictions in which they may operate; they lobby government for legislation favourable to their business; they seek new markets in other states of the union and abroad; and they identify their products, the children, as belonging to those who can pay to father them.

It is important to demonstrate these activities because they are significant in creating and perpetuating the common picture of demand and supply, and they are instrumental in fostering the notion that the *procreation* of human beings might honourably become the *production* of human beings.

For brokers, the portrayal of the arrangements as legitimate is essential. To place the practice of preconception arrangements in the best possible light, brokers continually reinforce the common depiction. Their promotional literature stresses the plight of "the infertile couple" and "the childless couple," thus seeking to legitimize demand for preconception arrangements.¹⁴⁸

Yet, the brokers themselves are aware that the couple will not necessarily be childless; for example, their own application forms ask prospective commissioners to give the names and ages of the children they have had with each other or in previous marriages.¹⁴⁹

Brokers do not rely exclusively on sentiment to justify their clients' desires; they also stress that participation in a preconception arrangement is, in fact, a "right." According to Keane,

society has a moral obligation to the infertile couple, [and] it hasn't addressed these issues for the longest time. Adoption doesn't solve the problem anymore and if somebody has this right, this constitutional right, it doesn't seem to me that it can be an immoral right that he has.¹⁵⁰

A commissioner might exercise the "right" to rear a child through a broker without first investigating adoption, provided that he has sufficient funds. According to one commentator, only 50 percent of commissioning couples

may have looked into adoption — so strong is their desire for a child that, at least partially, is biologically their own. As long as they can afford the fee, which generally ranges upward of \$25,000, it is unlikely that any surrogate parenting group will turn them away.¹⁵¹

Consistent with this "rights" approach, brokers do not screen prospective parents to ensure that the children will be transferred to good homes. As Levin said, "People have certain intrinsic rights and the ability to procreate is one of them. You or I don't have the right to tell people that they can or cannot have a child."¹⁵² Similarly, Keane told the CBS television news program, "West 57th,"

Keane: I may take most couples who walk in the door and I would stand on that position, because they have a right to a family, just as myself or anybody else.

Kroft: I mean, I'm single. If I told you, "Look Noel, I'd like to have a child." You can fix it for me?

Keane: Sure, if I was single and wanted a child, I'd do it for myself. I don't have any problem with that.

Kroft: What else could you do for me? Could you get me a male child?

Keane: Sure.¹⁵³

Provided always that he can pay.

In this way, the brokers' rhetoric alternates between eliciting sympathy for childless couples unable to have children themselves or by adoption, and stating that commissioners are entitled, as of right, to have a child. They rely on the common depiction of commissioners' characteristics and desires to create a climate of public acceptance for their activities and, when criticized, assert that commissioners are exercising their constitutional rights.

Brokers also rely on the common depiction of carrying women, which helps them both to recruit the women and to reassure the commissioners. In their promotional literature, brokers refer to carrying women as "special" and "super," perhaps to attract women who desire so to be known and to convince commissioners that, unlike Mary Beth Whitehead, the carrying women will relinquish the child. Keane's post *Baby M* brochure claims that

A surrogate is not a superwoman, but she is a super person, motivated to help another woman in an extremely sensitive situation. In most cases, she is married and knows the joy of having her own children and wants to help another woman to know that joy. She values her own family, her own life, and the benefits the payment can bring to her own children.¹⁵⁴

Handel's firm describes the women similarly:

Other criteria for participation in our program include her intelligence, stability and sense of self-fulfilment. She understands and believes from

the moment of conception, the child she is carrying was conceived so that a childless couple would have a family. The true genesis of the child is it's [sic] creation in the minds and hearts of the intended parents. The typical Surrogate Mother has a great deal of compassion for the plight of the infertile couple and is proud to be able to bring a child into their lives.¹⁵⁵

Whether the women actually live up to the description is not something the brokers will warrant. Keane's agreement with the commissioner, which is publicly available (unlike, for example, Handel's), does not promise that the carrying woman will relinquish the child. Nor do the brokers uniformly ensure from the outset that the women are likely to be capable of doing so. Keane is criticized for inadequately screening prospective carrying women. He does not appear to turn anyone away regardless of the results of the psychiatric investigation to which the carrying women must submit under the terms of the arrangement.¹⁵⁶

By contrast, Bill Handel claims that no carrying woman "used" by his firm has ever refused to relinquish the child. This might be the result of his tactics; despite how glowingly he describes them, he apparently threatens and intimidates each new recruit. According to one such woman, he said, "If I changed my mind ... he would drag me through the courts, sue me, and take everything I had. He said he would buy me a dog and let my kids fall in love with the dog and then he would kill the dog."¹⁵⁷

Handel's and Aigen's firms claim they screen prospective carrying women carefully and reject 95 percent¹⁵⁸ and 85 percent¹⁵⁹ of applicants, respectively. Whether in fact these brokers do turn away willing women, their statement that they are very selective is useful in fostering the image of carrying women as "special."

Despite what brokers might do privately, they actively reinforce the common depiction of supply by describing carrying women in glowing terms. Further, they tend to minimize the harm to carrying women of participation and to emphasize the benefits. Consider, for example, Levin's description of a carrying woman who gave birth to twins, one of whom died. Apparently the woman insisted that she arrange and pay for the child's funeral and burial. Rather than viewing this as a maternal reaction to neonatal death, Levin claims that the carrying woman was motivated by concern for the commissioners.

She wanted the natural father and his wife to be free to experience their joy and not to dwell on the sad aspects of the case ... That's the kind of outcome you can get if you structure things and screen people properly.¹⁶⁰

Similarly, Dr. Philip Parker, who, as stated above, assesses the contractual competence of prospective carrying women for Keane's Dearborn firm "for a flat fee of \$250,"¹⁶¹ minimized their grief reactions in his 1984 longitudinal study of 30 carrying women. He wrote,

After delivery, the surrogate mothers generally expressed transient grief symptoms which were highly variable. One stated that she had almost no consciously experienced feeling of loss. Some described varying

degrees of crying and sadness for several weeks. One surrogate experienced crying and sleeplessness for about one month. Another was crying and tearful and had difficulty sleeping for about five months beginning one month after delivery. Of importance in this last case is the fact that she also lost a close family member during the pregnancy.

Some surrogates stated that they felt most of their sadness in connection with the loss of the relationship with the couple rather than the loss of the baby.¹⁶²

But the experiences of this same group of women are described differently by Nancy Reame, who volunteered for Keane from 1981 to 1985¹⁶³ and assisted in the research.

Nearly all the surrogate mothers confessed that they had underestimated how difficult it would be to relinquish their babies. The symptoms of separation included uncontrollable sobbing, sleep dysfunction, aching arms, profound grief and the inability to look at any baby for several months without experiencing sharp, emotional pain. As a group ... the surrogate mothers lacked adequate legal protection. This was in contrast to the adopting couples, who retained skilled lawyers to draw up contracts which satisfied their needs.¹⁶⁴

While they might minimize the harm to women, brokers and their staff tend to stress the "benefits" of participation. According to Hilary Hanafin,

It's not unusual to hear that a surrogate has decided to go back to school and finish her degree, or put a downpayment on a house she's always wanted. I think it's a combination of finances and of also having achieved something unique that really gives that boost, that transition from being a housewife to attacking another career.¹⁶⁵

Hanafin has conducted research on carrying women, which apparently demonstrated "a lack of psychopathy in surrogates and no evidence of regret." (It is not clear whether Hanafin included in her study the well-known case of Diane Downs, who relinquished a child and almost exactly one year later murdered one of her remaining children and attempted to murder the other two.)¹⁶⁶

In addition to relying on and emphasizing the common portrayals of demand and supply, brokers appear to engage in damage control activities when the media are drawn to a case that deviates from the commonly presented pictures. For example, in the *Baby M*¹⁶⁷ case, the commissioners sued the carrying woman because she refused to relinquish the child to whom she had given birth. The *Baby M* trial lasted seven weeks, from January to March 1987, and, according to critics of the practice interviewed at the time, considerably damaged the public acceptability of the practice.

"I haven't heard any outpouring of people who think that this might be a good thing," a professor of legal issues in pediatrics at the Yale Medical School, Angela R. Holder, said. "I think more people are against it than before."

"Only in the last month has the full impact of surrogacy been understood," William Pierce, president of the National Committee for Adoption and a foe of surrogacy said. "Many people who saw surrogacy as ethically neutral and socially neutral and legally neutral are having second thoughts."¹⁶⁸

Probably as a consequence of the *Baby M* trial's bad publicity, a number of articles extolling the practice were published in diverse newspapers, copies of which are routinely sent to prospective commissioners by the Center for Surrogate Parenting in Beverly Hills, California.¹⁶⁹ Likewise, when the case was appealed and the Supreme Court of New Jersey condemned preconception arrangements in February 1988, brokers attempted to remedy the damage. On 23 May 1988, the *Los Angeles Herald Examiner* contained an article entitled, "Surrogate Mothers of Invention: Unlike Baby M, Most Cases End Happily," in which Handel's firm was again featured.¹⁷⁰

These *Baby M* damage control exercises were not limited to the print media. Noel Keane appeared on television during the trial and again when the appeal court judgment was rendered. On 5 February 1987, he said on "ABC Nightline,"

But for that agreement, this child would never have been conceived. And certainly if she found out that she made a mistake at the end, who should be more harmed? The father and infertile wife who brought [sic] this child, and the only reason this child was conceived, or this woman who now changes her mind?¹⁷¹

On the day that the New Jersey Supreme Court delivered its judgment, harshly critical of preconception arrangements, Keane attempted to minimize the effect of the decision on the practice:

Koppel: ... Attorney Noel Keane who's with us now ... helped set up the Baby M contract, as well as some 200 other surrogate mother arrangements. He is known as "the father of surrogate parenting." Mr. Keane, you heard Mary Beth Whitehead refer to today's New Jersey Supreme Court decision as, in effect, discrediting surrogacy. I take it you disagree.

Keane: I think I do. I mean, certainly the case didn't go the way we wanted it to, but overall we can look at the picture and say that surrogate parenting works, and it solves a real need in this country.¹⁷²

This ability to gain media attention is useful to brokers because it enables them to attempt to restore the common portrayal of the practice that is so essential to the operation of their business. Media attention is beneficial also because it helps defray the costs of advertising for commissioners and prospective carrying women. According to two commentators,

A lot of potential surrogates hear about agencies through the media. Noel Keane and Infertility Associates International [a firm operated by a Washington woman, Harriet Blankfield] get enough self-motivated

women through free publicity — articles about the agencies in the news media, appearances on television, etc.¹⁷³

Although the Whitehead-Stern arrangement brokered by Keane went notoriously awry, "inquiries from couples seeking [Keane's] help ... quadrupled in the wake of the *Baby M* publicity."¹⁷⁴

Yet, brokers are not totally reliant on media attention for publicity. They advertise in newspapers and college newspapers, both in the initial struggle to become known¹⁷⁵ and even when their brokerage house is "established."¹⁷⁶ As has been discussed,¹⁷⁷ Noel Keane has created a recruitment video entitled "A Special Lady," designed to increase the number of carrying women and commissioners who deal with him.

In addition to advertising, brokers, like other business people, lobby government for favourable legislation and search for jurisdictions in which they may legitimately operate. Keane worked with Richard Fitzpatrick, a Michigan State Representative, "to attempt to convince legislators to adopt a special surrogacy law."¹⁷⁸ Levin and Blankfield testified before the House of Representatives Subcommittee on Transportation, Tourism and Hazardous Materials in October 1987, on a bill that would have made paid and commercial preconception arrangements criminally illegal, and would ban advertising. They both argued the great need and desperation of childless couples. They claimed that the best legislation would be the regulation of brokers rather than a ban that would leave consumers and suppliers without the screening and other protection offered by brokers.¹⁷⁹ In 1989, Handel's firm announced it had been asked by a California legislative task force to provide model legislation for study by the committee.¹⁸⁰ Brokers view regulation as necessary for the growth of their businesses. Handel would like to expand his market to include commissioners who are unmarried and fertile but he aims first "to make surrogate parenting as palatable to the general public as possible. We are trying to get legislation passed."¹⁸¹

In addition to attempting to create a favourable legal climate for their business activities, brokers are apparently willing to shop for a forum in which they may pursue their activities. To carry on business when Michigan passed legislation designed to close his agency, Keane opened an office also in Nevada.¹⁸²

Brokers have also looked for new markets abroad but have had little success. Harriet Blankfield of Washington, DC, opened a satellite office in Surrey, England, in 1984. When she announced that her goal was to become a multinational enterprise — "the Coca Cola of the surrogate motherhood industry" — and that her British operation was fully functional, she provoked outrage in Britain.¹⁸³ When, partly in a reaction thereto, the government made the activity of brokers criminally illegal, Blankfield's operation closed its doors.¹⁸⁴

Keane's foreign enterprise fared no better. On 1 October 1987, he established a firm called United Family International in Frankfurt, which

would refer would-be commissioners to Keane's Michigan office. But German women from a Frankfurt women's health centre quickly formed a broad coalition with women from an international feminist organization, churches, political parties, associations, and trade unions to denounce Keane's activity.¹⁸⁵ On 7 January 1988, a West German court ordered the immediate closing of the office on the grounds that it violated West German adoption laws and contravened basic moral principles.¹⁸⁶ Thus, by attempting to expand their operations, brokers have demonstrated that, like other business people, they will continually seek new markets for their products.

Clearly, brokers transform procreation into production. Even more significantly, their business serves to make irrelevant to the determination of who will rear a child, the central activity of women in procreation. This fact is most obvious in an examination of Handel's firm.

The Center for Surrogate Parenting offers three means to commission children. The first two, genetic-gestational and exclusively gestational arrangements, are the subject of this study. The third does not sever gestation from rearing and, therefore, has not hitherto been discussed. This third method is "ovum donation." It consists of a woman submitting to egg extraction for a fee (thus it is not "donation"). Then the embryo is transferred into the commissioning woman's uterus for gestation. If the procedure succeeds, the commissioning woman will give birth to a baby who is genetically related to her husband and the egg seller.

Given these three ways in which commissioners may buy Handel's "services," how does his firm determine who will be the rearing mother? Handel's practice is designed to ensure that the rearing mother is not determined with reference to her bodily process of either ovulating an ovum that became the child, or of gestating that child, or both. According to his methods, the rearing mother is determined by first discovering which man is genetically related to the child and then by looking for that man's wife or partner. Thus, Handel's practices entail that the mother of a child is not identified by biology at all, but by her social relation to the sperm contributor who originally had sufficient funds to set the process in motion. The experience of one genetic-gestational woman illustrates the effect of this commercial method of determining maternity:

The last day I was in the hospital, the gynecologist for the surrogate company came into my room. I was sitting there crying. Alice [the commissioning woman] was holding my baby. She wouldn't let me hold him. She said to the doctor, "By the way, I'm Harry's wife." And he said to her, "Oh, I'd like to congratulate you."¹⁸⁷

The production of children entails that a child's rearing parents be identified by tracing contributions of money and sperm irrespective of what a particular woman has endured to bring the child into the world.

By generating and legitimizing demand and ensuring supply through reliance on misleading portrayals, which they act quickly to restore when

attacked; by seeking publicity and advertising; by shopping for hospitable jurisdictions in which to operate; by lobbying government for favourable legislation; by seeking new markets abroad; and by determining motherhood, not biologically but through social status, brokers make a business of babies. In all these ways, brokers have industrialized procreation.

In Vitro Fertilization Practitioners

Apart from brokers, there is a second group of people whose interest in preconception arrangements is significant and, therefore, worth assessing. Although Canadian infertility clinics have not undertaken embryo transfer in preconception arrangements, one clinic, associated with the Foothills Hospital in Calgary, is considering it.¹⁸⁸ The practice does, however, currently take place in the United States. Arguably, medical practitioners conducting IVF might encourage the practice of exclusively gestational arrangements for three reasons related to self-interest: namely, to increase the overall success rates of their IVF programs; to increase the opportunities to conduct research; and to increase the market for their services. We shall consider each of these in turn.

IVF is a technology with a high failure rate. In 1988, the U.S. Congress OTA reported "the most comprehensive data on IVF success rates in the United States come from 41 clinics that treated 3 055 different patients in 1986."¹⁸⁹ The data revealed that "embryo transfer led to a live birth less than 11 percent of the time" and "about 6 percent of the initial stimulation cycles resulted in a live birth."¹⁹⁰ At the most expert IVF programs, "embryo transfer led to a live birth about 15 percent of the time."¹⁹¹ The OTA hypothesized that clinics that succeed most often might become victims of their own success.

It may be difficult for the most expert IVF programs to sustain their success rates as their good reputations attract patients with the most difficult cases of infertility (e.g., unexplained infertility). Similarly, an increase in the average age of patients would likely trim an IVF program's success rates.¹⁹²

To increase the success rates by which they are evaluated, IVF practitioners might be tempted to have as patients women who are more likely than their average patients to carry a transferred embryo to term. The practice of exclusively gestational arrangements furnishes such a group of women. In the first instance, gestational women tend to be much younger than commissioning women.¹⁹³ Secondly, they participate on the basis of their demonstrated ability to carry a child to term.¹⁹⁴ Thirdly, an embryo is transferred into their bodies, which have not undergone the hormonally induced egg extraction process that may impair the success of IVF.¹⁹⁵

Not surprisingly, IVF performed on young, fertile, and drug-free carrying women has been reported to be more successful than IVF performed on older women believed to be infertile whose natural hormone cycles have been chemically altered. A Cleveland IVF practitioner stated,

Our initial results are encouraging in that the six pregnancies reported here occurred in a total of 20 patients [i.e., carrying women], undergoing 33 cycles, and 27 embryo transfers. This provided a 22% conception rate and an 18.5% ongoing pregnancy rate with an average of only 2.3 preembryos per transfer.¹⁹⁶

In another report, Handel and Hanafin claimed that 22 embryos were transferred after IVF, and seven children were born alive.¹⁹⁷ This success rate of 31.8 percent using young, fertile, drug-free women as carriers is significantly higher than the 11 percent reported by the average U.S. clinic, and the 15 percent reported by the most expert clinics, all of which tend to practise on older women believed to be infertile and who receive hormone stimulation. As Handel concluded before an international assembly of IVF practitioners, "It is clear that placing embryos in young women with unstimulated cycles results in a most favourable situation for pregnancy. The number of gestational surrogate procedures is increasing dramatically."¹⁹⁸ By practising IVF — an "infertility treatment" — on young, fertile women, IVF practitioners are likely to claim an increase in the "success" rate of this hitherto largely unsuccessful practice. (In the process, IVF practitioners claim success for what nature could have achieved without interference: to render the young, fertile women pregnant.)

A second possible advantage to IVF practitioners of exclusively gestational preconception arrangements is that they enable practitioners to conduct research on IVF itself. Practitioners cite the potential for increasing knowledge, and thus arguably also advancing their career interests, as a benefit of gestational arrangements.

These patients [the commissioners and the carrying women] also provide a unique opportunity to examine several facets of human reproduction. Of particular clinical interest is the nature of the embryo-endometrial relationship which permits implantation.¹⁹⁹

A third advantage of the practice of exclusively gestational arrangements is that it provides a new market for practitioners' services. IVF was originally developed to transfer embryos into the woman from whom the ovum originated. The original practice required that the woman have functioning ovaries and a uterus and that she otherwise be capable of carrying a child. When, however, the original technique is altered by transferring the embryo into a second woman, the group of people who might seek IVF is considerably increased,

not only to [include] hysterectomized women, but also ... those with unexplained and recurrent abortion, congenital uterine anomalies, severe uterine abnormalities after diethylstilbestrol administration, or uterine disease or scarring that precludes successfully continuing a pregnancy to term.²⁰⁰

This increased group of women could, according to the President of the Pacific Coast Obstetrical and Gynecological Society, be attended "with the

combined specialty services of geneticists, gamete biologists, reproductive endocrinologists, perinatologists, and reproductive surrogates.²⁰¹

IVF practitioners argue that this augmented group of candidates for their services requires their services as a matter of medical necessity and present the modified form of IVF as a form of medical treatment. According to Patrick Steptoe, who assisted in the birth of the first child conceived by IVF, "There are some couples who need surrogacy on very strong medical indications."²⁰² Dr. Richard Marrs, an IVF practitioner who works with Handel's firm, said, "There are some very good medical reasons why the use of gestational surrogates is absolutely necessary for certain women."²⁰³ In the public hearings of the Royal Commission on New Reproductive Technologies in Vancouver, Dr. Christos Zouves (formerly of the IVF program at Vancouver's University Hospital and now in California at a reproductive technologies centre) was of the same view in his reply to questions put by the Commissioners. In an exchange, he suggested that not only are exclusively gestational arrangements medically indicated, the "treatment" is offered primarily by his team of physicians and scientists:

Dr. Zouves: ... I believe that there is a medical indication for surrogacy in certain patients who have medical conditions which make them unable to carry a pregnancy. So those would certainly be patients that we would look to offering surrogacy to in the first instance.

Dr. Jantzen (Commissioner): I'm sorry, I don't understand. How could you offer surrogacy? I would have thought it would have to be a woman who would offer surrogacy.

Dr. Zouves: Given that there would be medical interventions required along the way, I was using the term "us" in that context. It would obviously have to be a woman carrying this pregnancy for another woman.²⁰⁴

Not only do some IVF practitioners claim that certain women *need* to have their genetic material brought to birth by another woman (and thus the practitioners' services), but some also claim that the arrangement is in the interests of the child. According to University of Toronto law professor Bernard Dickens,

"one now finds some physicians speaking about the gestation of choice, that is they are saying surrogacy can be positively good for the individual child," [Bernard Dickens] said. This would include cases where prospective mothers have diabetes. Diabetes does not necessarily preclude pregnancy, but a mother's diabetes could damage a fetus.²⁰⁵

The President of the Pacific Coast Obstetrics and Gynecological Society has also professed a concern for the health of the child in encouraging the practice of exclusively gestational preconception arrangements:

Consider the woman with chronic hypertension, renal disease, or inflammatory bowel disease or others who are condemned, through poor placental perfusion and inadequate fetal nutrition, to produce underweight, undernourished, and marginally healthful fetuses, many

of whose growth and development will continue to lag through adulthood. Must we insist that these fetuses be placed at risk for being ill-born and enfeebled for life? They could be wellborn, healthy, and whole simply by being allowed to grow within another woman's uterus.²⁰⁶

Sandberg rhetorically asks why such women should be "consigned to the abusive production of a thin, pathetically undernourished and possibly embryologically damaged infant"²⁰⁷ when a "healthy, fat, bubbly baby" is possible through the "specialty services" of "surrogate carriers" and medical practitioners. Not only does Sandberg think it wise for such women to avail themselves of his colleagues' services, but he argues that if such women do not, they should be punished by the state:

[S]hould not the woman be held criminally accountable who knowingly permits herself to produce a sickly child whose entire life will be encumbered by imperfections of health and structure when the prevention of such was possible and available?²⁰⁸

In Sandberg's opinion, a large number of women ought legally to be required to delegate their procreative role to the paid specialists. As he says, "No one need be denied. What a wonderful time in which to live."²⁰⁹

The practice of exclusively gestational preconception arrangements has the potential to advance the interests of IVF practitioners in increasing the low IVF success rates, the opportunities for IVF research, and the market for their "specialty services."

In summary, this section has demonstrated that by failing to attend to the significant interests of brokers and infertility practitioners, the common depiction of the practice of preconception arrangements is incomplete and misleading.

Harm and Potential Harm of the Practice

The common portrayal of preconception arrangements fails in yet another way. It takes insufficient account of the actual and potential harmful effects to the parties in the agreements and to other persons affected by the arrangements. The persons harmed or potentially harmed by the practice include the carrying woman, the commissioned child, the carrying woman's other children, her husband or partner, her parents, and the commissioning woman. That the common portrayal does not include or refer to these harms and potential harms is significant because even proponents of the practice admit that it might be prohibited or limited by the state by evidence of tangible harms to others.²¹⁰

The investigation of whether such harms exist is severely hampered by the lack of comprehensive data on the subject. As has been discussed at the outset of this part, there are no independent studies of the long-term impact of the practice on participants and other affected parties. Given that the practice has taken place for at least 12 years, the argument of its "newness" is no longer sufficient justification for the lack of such studies.²¹¹ Nevertheless, analysis of proponents' arguments for legislative policy

requires an assessment of the practice's outcomes. Consequently, what data are available must be reviewed. At the moment, the immediate outcomes are known only by anecdotal accounts; the long-range effects can only be hypothesized by examining social science data of analogous practices.

Harm to the Carrying Woman

Carrying women may be harmed by preconception arrangements in a number of ways. They are subject to the ordinary physical risks of pregnancy and the uncommon but attendant risks of miscarriage, stillbirth, complications, and death. Carrying women are encouraged to deny their relationship to the child growing within themselves, and are required by the agreement to sever their relationship with the child by surrendering it; thus, they can suffer serious, harmful, long-term psychological effects. In paid agreements, relinquishment for payment requires the woman to rationalize the exchange of her baby for money, with the tension that causes. If the woman attempts to retain custody of the child, she might face a court battle and must cope with having denied the commissioners the child they sought. Further, if the carrying woman is in a conjugal relationship, her decision to retain custody will entail bringing her child by another man into that relationship.

Participation by a carrying woman in a preconception arrangement involves her entire body. In genetic-gestational arrangements, all the physical risks of conception, gestation, labour, and childbirth are borne by her. In such arrangements, the woman is usually inseminated by a physician using the commissioner's sperm. Unless precautions are taken by high standards of practice, a genetic-gestational woman might thereby be exposed to infections, venereal disease,²¹² and acquired immunodeficiency syndrome (AIDS), which threaten health, future fertility, and life itself. Apart from this physical risk, the procedure may have negative psychological effects. According to a medical journal report, one woman described her experience

in very negative terms. It even had overtones of an "affair" in the way that it was conducted by the surrogacy program. Mrs. H. would travel to another city, meet the adopting couple at the physician's office, eat dinner with them, and stay at the same hotel. It was during these meetings she found she did not like the biological father or carrying his baby. She felt "dirty" following the sperm inseminations, would immediately bathe numerous times, and described other behaviors and feelings more typical of a rape victim.²¹³

If conception does not occur soon enough for the broker and commissioners, the woman may be asked to take fertility drugs, with their known risk of adverse side-effects.

If too many cycles go by without a pregnancy, Dr. Jeffrey Levitt [a Maryland fertility specialist] puts the surrogates on Clomid, which stimulates ovulation. "Yes, we get them ovulating," he says. "I don't give

Clomid because of pressure but a lot of surrogates are not from this state. They will come in and the husbands [i.e., the commissioners] will fly in, so you may have to modify things. Suppose somebody has an irregular cycle. Well, you've got to make them regular, so there are things you do. If I speed up things, it's because I feel it's ethically acceptable.²¹⁴

In exclusively gestational arrangements, the pregnancy is initiated by embryo transfer, which can be painful, as one woman explains:

"They have this catheter, and they run it up through the vagina and the cervix into the uterus ... That hurts a lot, because to get through the cervix, they use these long scissors [forceps] to hold it open. It was just like being in labor!" Kandy went through the embryo transfer three times before achieving pregnancy.²¹⁵

In addition, there are the physical risks to carrying women that are associated with any pregnancy, including

complications which may harm or, rarely, kill ...; the discomfort [on average a pregnant woman suffers six to nine symptoms], the reduced physical and social activity; and the emotional stress ... [t]he pain of birth ... [p]ossible changes in the body ... weight changes, varicosities and breast distortion.²¹⁶

One such complication was experienced by a Michigan carrying woman:

"She was sitting at home one evening, watching TV," recounts Carmen Dubois, the mother [sic] of the child Maria gave birth to, "and suddenly her placenta tears away. Maria's husband rushed her to the nearest hospital. She was dying from the loss of blood." Clinically she was dead — twice, but she was revived and survived. After three weeks in the hospital both she and her healthy baby were discharged.²¹⁷

Women who conceive in the usual way and later have a miscarriage suffer psychologically.²¹⁸ Whether the findings regarding miscarriage generally are also applicable to commissioned pregnancies is not known. However, one study of (non-commissioned) pregnancies showed that even where 72 percent of the pregnancies were unplanned, 89 percent of the 93 women reported at least one negative feeling of unhappiness, depression, anxiety, or hostility.²¹⁹ One genetic-gestational woman describes her experience thus:

[A]fter the fifth insemination ... I knew that I was pregnant. Ten days later I was tested and it was positive. I cannot describe our elation. We called Keane's office. The [commissioners] called us, jubilant. They sent me flowers. We were all in the clouds with happiness. Over the July Fourth weekend, I was helping my mother-in-law at a family yard sale when I suddenly had severe cramping and felt very ill. I was taken to Central Michigan Hospital, where I found out I was miscarrying.

In a couple of days, I was better physically. But emotionally I was a wreck. I felt lost and unable to concentrate on the future.²²⁰

The potential physical harms can be exacerbated by the fact that the broker, his colleagues, and the couple who encourage the initiation of the pregnancy are not primarily concerned with the mother but with the child whom she is to "produce."²²¹ Consider the case of "Jane Doe," a carrying woman who, at the age of 25, had suffered five miscarriages in nine pregnancies and had undergone an operation for cervical cancer.²²² Even when the doctors were told of her history they apparently commented only that she was "really fertile." She was given drugs to induce ovulation even though she was nursing her son; she was inseminated and then, 22 weeks later, she delivered a baby that died one and one-half hours after birth. Carrying women such as Jane Doe, who experience a stillbirth or perinatal loss, probably suffer, though to what extent is not known, the considerable "pain and bereavement" and "affective distress" of other parents following perinatal loss.²²³

The risks to the carrying woman's health can be increased pursuant to the terms of the agreement at the option of the commissioner. According to Keane's agreement, the carrying woman agrees "at the request of the attending physician to undergo amniocentesis ... or similar tests to detect genetic and congenital defects."²²⁴ The test is invasive, has a small risk of infection or miscarriage, and might be perceived by the carrying woman as a "quality control check." According to Mary Beth Whitehead,

Bill and Betsy [the commissioners] had gone off to Europe for a vacation. When they returned, they said they wanted me to have amniocentesis performed. My doctor said that I didn't need it, but they insisted, saying that they didn't want a baby with a handicap, they wanted a "perfect" baby.

I drove to the hospital myself. Betsy and Bill met me there. I didn't want to be there ... I was very nervous, and the baby's heartbeat became irregular, indicating that she, too, was in distress as they drew the fluid out of me.²²⁵

The greatest risk to the carrying woman is that she might die from the pregnancy. Although maternal mortality rates are very low in North America,²²⁶ at least one woman has died by participating as a carrying woman.²²⁷

In addition to these harms, there is another aspect of participation that might be harmful: as a group, carrying women tend to deny the child they carry is their own child. This denial is reinforced by the brokers, their staff, and the commissioners.

That genetic-gestational women deny that the fetus they are carrying is their own has been observed by at least two psychologists. A clinical psychologist who screens women for a broker in New York said that these women "from the beginning ... lack the usual emotional tie. They don't perceive [the child] psychologically as theirs."²²⁸ Similarly, Hilary Hanafin, of Handel's firm, claims that most women feel toward the child as they would toward a niece or nephew: "And I hear this without prompting them.

We even had several surrogates express surprise that the baby looked like them. That's how much they've denied their contribution to the process."²²⁹ Carrying women frequently use language denying the child is their own child.²³⁰ This perception that the child of carrying women is not their own is reinforced by brokers and their staff. Although Hanafin has said she does not encourage such denial, she does imply that she would not be content to let carrying women believe they are mothers.

Most surrogates think of it as the couple's child ... This happens without any coaching from the Center. We don't encourage this attitude, confront it or challenge it, if that's the way they've chosen to cope with it. If they see the child as shared, that's okay. If they think of it as theirs then we would look at the situation more closely.²³¹

Noel Keane, however, is more blunt. After the *Baby M* trial decision was rendered, he said, "She has to realize that she is carrying their child."²³²

As we have seen,²³³ this denial might make it easier to relinquish the child and thus work to the advantage of the broker. Yet it is not known whether denying the truth is harmful to the carrying woman. Until comprehensive longitudinal studies are conducted, the effect of denial cannot be fully appreciated. Anecdotal evidence suggests, however, that it can be harmful. For example, according to Elizabeth Kane, seven months after relinquishing her child, she

began receiving photographs of a beautiful brown eyed infant with chubby cheeks. He no longer looked exactly like his father as he did at the time of birth. Instead, the top half of his face was identical to mine. Only then did I recognize the fact that he was MY SON, too. He would carry my genes with him from one generation into the next. And I had exchanged the right to never see him again for \$11 500.

I sank into a deep depression and had no interest in being a useful human being. I began to contemplate suicide ... I struggled for a long time to regain some stability and rational thinking.²³⁴

In 1987, Kane said that the very term "surrogate mother," in suggesting something less than full motherhood, is part of a pattern of deception from which all carrying women awake. "We birth mothers call it the 'big sleep' and eventually they will all wake up from this denial and realize what they've done."²³⁵

Another potential harm to the carrying mother is caused by the very essence of the agreement that she relinquish the child at birth.²³⁶ Without longitudinal studies of the effects of the practice, it is not possible to know whether carrying women are harmed in the long run by relinquishment. Anecdotal accounts reveal that at least two women who agreed to relinquish children, with apparently little distress at the time, subsequently suffered from the experience. The story of the first woman, Elizabeth Kane, has already been related.²³⁷ Carol Pavek, whom Lori Andrews describes as "a booster of the surrogacy concept"²³⁸ and an "articulate feminist [who] talked persuasively about women's reproductive freedom and how surrogate

motherhood was a pillar of that freedom,"²³⁹ surrendered three boys under preconception agreements. When her first child was nine years old and after the relinquishment of her other three children, she tried to have a fifth child whom she would keep, but instead she delivered a stillborn boy. After that stillbirth,

Carol was doing a massive soul search, about this pregnancy and about her previous three pregnancies as a surrogate mother. Carol told Rick [her husband] that she didn't want to take any phone calls, and that she especially did not want to talk to Rhonda, the East Coast woman for whom Carol had [twice] been a surrogate.

One day, Carol picked up the phone and Rhonda was on the line ... Rhonda was soothing and sensitive, but Carol explained how difficult it was to talk to her. "It's through no desire to take your sons away," explained Carol. "I just think that it's unfair that someone else has two beautiful sons and I didn't get one."

... Carol's friends say the death has hit her harder than she realizes. With the three healthy babies out there, they wonder, could Carol become another Mary Beth Whitehead?²⁴⁰

The experience of Kane and Pavek suggests that the effect of relinquishment on carrying women might change over time, and therefore the claims of proponents that the arrangements have "worked out just fine"²⁴¹ ought to be treated with reservation. The long-term effects of relinquishment on carrying women are simply not known.

The effects of relinquishment in adoption are known and might have some relevance in predicting the long-term outcome of preconception arrangements on carrying women. Proponents argue, however, that adoption is not analogous to preconception arrangements. For example, Hanafin claims that the decision to relinquish children for adoption differs radically from the decision to relinquish under a preconception arrangement.

The birth mothers in the traditional adoption situation are much more apt to have an attachment to the child and to be very worried about who the parents are going to be. The birth mother is selecting a couple to raise a baby that she may desperately want to keep, but she's sixteen years old or twenty-two years old, can't afford to raise a child, and the father's taken off.

The surrogate mom sets out to deliberately create a child for another couple. She too is concerned about who the parents will be, but her feeling about how to select them tends to be different. A surrogate mother is often looking for a couple she will enjoy working with, be able to relate to and have a positive experience with. And be good, loving parents. She is not looking for someone to raise her baby. That's a very different perception.²⁴²

Andrews similarly claims that adoption is not analogous. Discounting the experience of pregnancy and childbirth, Andrews quotes with approval

Lisa Newton, a professor of philosophy, who claims that the carrying woman merely performs a service that "is a simple extension, as far as I can see, of baby-sitting and other child-care arrangements which are very widely practiced."²⁴³ Further, according to Andrews, carrying women are not as vulnerable as women who relinquish under adoption. They tend to be older, to have other children, and to be deliberately seeking to conceive a child for relinquishment.

In fact, we should be much more concerned about the exploitation of girls and women in the traditional adoption situation than about surrogates who, for the most part, are engaging in arms-length transactions with the opportunity to be represented by counsel ... the consent of biological mothers in the adoption situation is more suspect than consent in the surrogate situation — and the potential for wrenching psychological damage is greater.²⁴⁴

Contrary to Hanafin, Andrews, and Newton, however, it is possible that carrying women do suffer "wrenching psychological damage," for the fact is that their relationship with their child is not at "arm's length." In genetic-gestational arrangements, the child is theirs in just the same way that a child is the child of a woman contemplating adoption. The significant difference is that, in the first case, the decision to relinquish is made prior to conception; in the second, usually no conception was intended. In both cases, the woman experiences pregnancy, labour, childbirth, and lactation. In each case, the woman who gives birth to a child surrenders it to others with whom she (usually) will have no contact. When one considers a more comprehensive portrayal of preconception arrangements than the common depiction, it appears that adoption and preconception arrangements share many similarities. Some important aspects of adoption are descriptive also of preconception arrangements:

1. Although usually construed as "voluntary", relinquishing mothers can feel that relinquishment is their only option in the face of financial hardship, pressure from family or professional persons.
2. The child continues to exist and develop while remaining inaccessible to the relinquishing mother who might one day be reunited with the child. It might be difficult to say goodbye with any sense of finality.
3. Lack of knowledge about the child can permit the development of a variety of disturbing fantasies, such as the child being dead, ill, unhappy or hating her or his relinquishing mother. The guilt of relinquishment, if any, can thereby be augmented.²⁴⁵

Because of the significant similarities²⁴⁶ between these two practices from the perspective of the relinquishing mothers, the post-partum experience of relinquishing mothers in adoption might well be relevant to understanding the potential long-term effects of relinquishment on carrying women.

Research²⁴⁷ concerning the effect on women of relinquishing a child for adoption reveals that the event is not a transient one. On the contrary, it can be of major and enduring significance in the relinquishing women's lives and have prolonged effects on subsequent life functioning.²⁴⁸ According to one researcher,

Relinquishing a child for adoption presents the mother with a discordant dilemma of separation and loss. First, the separation is permanent and was initiated by the relinquishing mother. Second, the loss is irresolvable because the child continues to exist. The [permanent] and volitional disengagement from her infant, who is alive and developing, inauguates a significant maternal stress.²⁴⁹

One study of 334 relinquishing women demonstrated a very high incidence of pathological grief reactions that remained unresolved even though many years had elapsed since the relinquishment.²⁵⁰ Another study of 218 women concluded that

The effects of relinquishment on the mother are negative and long-lasting. Approximately half the women reported an increasing sense of loss over periods up to 30 years, with a sense of loss being worse at particular times, e.g. birthdays, Mother's Day. For the sample as a whole, this sense of loss remained constant for up to 30 years. Relinquishing mothers compared to a carefully matched comparison group of women had significantly more problems of psychological adjustment.²⁵¹

In a study of 20 women, the most striking finding was that the majority reported no diminution of their sadness, anger, and guilt over the considerable number of years since relinquishment. Over half of the women suffered from severe and disabling grief reactions that were not diminished with time and that manifested themselves predominantly as depression and psychosomatic illness.²⁵² The study of 334 relinquishing mothers concluded that to relinquish a child for adoption is to suffer a serious permanent loss and that "grief over a surrendered child appears to remain undimmed with time."²⁵³

Whether these findings are applicable to preconception arrangements where a woman conceives with the intention to relinquish the child is not known. Longitudinal research ought to be conducted to determine the long-term effects of relinquishment on carrying women. It is significant, however, that Parker's 1984 study of 30 women revealed a number of reactions to relinquishment that were similar to those described by researchers examining relinquishment in adoption. His findings show that, like the women who relinquish children in adoption, carrying women can suffer grief, anger, and sadness, which are accentuated on the child's birthday; and they can have difficulty in resolving the grief, a desire to be reunited with the child, and a desire to have a replacement child to retain or to relinquish.²⁵⁴

Although research must be done to test the hypothesis, it is plausible that women's experiences of relinquishment in adoption and in preconception arrangements are similar and that genetic-gestational women will similarly suffer serious, negative, and long-lasting effects from relinquishment.

What will be the long-term effects of relinquishment on women who carry an embryo genetically unrelated to them? There is no research at all on this subject. Some male medical practitioners have speculated that, because the child will originate from gametes foreign to the woman, she will not grow emotionally attached to the child. For example, Patrick Steptoe said that since the child is "the genetic offspring of the commissioning parents, [this] eases the doubts about the status of the child, and, probably, the question of the surrogate mother giving up the child."²⁵⁵ The same argument was made by infertility practitioners Leeton, King, and Harman, who have written that where

the surrogate contributes none of her own gametes [the] situation has the advantage that the infertile woman is the biological mother, which reduces the hereditary effect of the surrogate on the nature of the child as well as possibly reducing the maternal feelings of the surrogate towards the baby.²⁵⁶

But it is not clear that the carrying woman's maternal feelings will be any less for a baby that she is not genetically related to. In both cases, the woman's body is engaged for nine months in nourishing, protecting, and then delivering the child. After delivery, her body prepares to feed the baby. The physical effect on the woman is great and is no different if the ovum comes from another woman.²⁵⁷ Whether the effects of relinquishment on her will be the same as the effects of relinquishment on birth mothers in adoption is not known; again, longitudinal research is needed to determine the outcomes of exclusively gestational preconception arrangements.

If carrying women do suffer from relinquishment in a manner similar to that of birth mothers in adoption, one might ask how this harm to carrying women can be used to argue against the practice of preconception arrangements but not also against the practice of adoption. The answer is that from the perspective of minimizing harm, adoption is relevantly different from preconception arrangements. The decision to transfer the child in adoption is made *after* conception, not before. As one commentator writes, the two practices have fundamentally different motivations:

Adoption seeks to find rearing parents for children without them; surrogacy seeks a child for would-be rearing parents. Adoption places the interests of the child first; surrogacy places the interests of the adults first.²⁵⁸

Family law does not encourage the practice of adoption but views it as a "necessary evil."²⁵⁹ It recognizes the harm it causes to the birth mother and "is carefully hedged around with reminders that the mother is yielding her child for adoption only under the pressure of exigent circumstances, only

in the child's interests, and only at painful cost to herself."²⁶⁰ That birth mothers suffer when they relinquish their child for adoption is hardly an argument for increasing the number of women potentially so harmed. As Mary Beth Whitehead said, "I think adoption helps solve a problem. I think surrogacy creates problems."²⁶¹

Thus, data clearly show that relinquishment in adoption causes serious harm to birth mothers. Birth mothers in preconception arrangements are in a similar position and are therefore at risk of serious harm. Whereas adoption causes maternal harm incidentally in attempting to cope with an unintended conception and in the best interests of the child, preconception arrangements intend the conception despite the likely harm to the birth mother and because of the interests of the adults. From the perspective of maternal harm, adoption and preconception arrangements are relevantly similar. From the perspective of public policy, the two practices are relevantly different.

The potential harm to carrying women is not limited to harm caused by relinquishment. A carrying woman might suffer harm even if she does not relinquish the child. If the commissioners decide to sue her for custody and for a declaration of parentage in their favour, she might be vilified in the publicity attendant upon a trial. Mary Beth Whitehead claims she experienced such suffering.

I'm no villain. People come out of prison and aren't treated like I've been treated. I didn't kill anybody. I didn't violate anybody's rights. My rights were violated. Nobody likes to be hated, but the whole world hated Mary Beth Whitehead.²⁶²

Should the commissioners take the opposite course of action and acquiesce in her decision to keep the child, a carrying woman might suffer nevertheless. If carrying women are indeed motivated to help childless, infertile couples, they might feel badly that the couple will not have the child to raise. A carrying woman who gave the child to the commissioners in their motel room and then changed her mind when she got to the elevator and returned to their room to retrieve him said, "Sometimes I think, my God, that poor couple ... What I've done to them. I feel horrible for the love I feel for this baby. How am I ever going to tell him I took him away from someone who wanted him?"²⁶³

A second aspect of the decision to retain the child is the possible effect its presence might have on the carrying woman's marriage or partnership. The child is not the child of her partner and might not be accepted by him. Further, if the decision to enter the arrangement was motivated partly or entirely by financial concerns, the family's resources will be strained not only by the lack of the expected income but, more significantly, by the unanticipated costs of rearing the child, which the husband or partner might well resent.

Thus, the carrying woman in a preconception arrangement may be significantly affected in harmful ways by her participation in the

arrangement. There are potential physical and psychological risks associated with the insemination (or embryo transfer), gestation, labour, and childbirth; with the denial that the child she carries is hers; and with either the relinquishment of or the decision not to relinquish the child.

Harm to the Commissioned Child

The potential harms of preconception arrangements extend beyond carrying women. Commissioned children might also be harmed by the circumstances of their conception and birth. Like children born of donor insemination or children who do not know one of their genetic parents, commissioned children born of genetic-gestational arrangements might experience bewilderment and feelings of loss, just as has been documented for adoptees. They might also be at risk from the possibility or fact of having been rejected by the commissioners, and by the knowledge that they were bought at a price.

According to Steven Nickman, clinical instructor in Psychiatry at Harvard Medical School, growing up as an adopted child involves losses, risks, and deprivations affecting the development of personality. One risk is the loss or disruption of existing attachments; a second arises from having an appearance different from the adopters or otherwise having it known by others that one is "different." A third, complex class of risks arises from social and intra-psychic factors: the knowledge of having been relinquished affects self-esteem; the lack of knowledge about one's original parents causes adoptees to feel that their status in society is ambiguous.²⁶⁴

Commissioned children conceived by insemination who are relinquished are usually surrendered to the genetic father. As a consequence, the child will know one of its genetic parents but may be at risk in the three ways identified by Nickman: the child's attachment to its birth mother is severed; the child might appear like its birth mother, not the commissioners, and in any event is "different" because of its unusual conception; and the child was given up by its birth mother. Even if the carrying woman does not relinquish the child, the child might suffer because it does not resemble its half-siblings (the carrying woman's other children) and it may lack knowledge of, and a relationship with, its genetic father. The child in this situation also potentially faces hostility from its stepfather.

If the child is conceived by embryo transfer and later relinquished, it might never know the woman inside whom it lived for nine months and who gave it birth. Whether this would have any emotional consequences for the child is not known. If she does not relinquish the child, it might suffer from not knowing its genetic parents. Whether a child's self-image is altered as a result of being genetically unrelated to the woman who gives birth to it, and whether others who know of the child's origins would therefore relate to it differently, is also unknown.

Commissioned children might also suffer from the knowledge that the commissioners had the option to, or actually did, reject them.

Commissioners have the option to require an amniocentesis test of the carrying woman. Although they cannot legally require her to have an abortion, they can make it clear they would not accept an "abnormal" child. Some commissioners have actually rejected commissioned children, as has been described above.²⁶⁵ In another case, the child conceived by a woman and her brother-in-law who was born seropositive for the human immunodeficiency virus (HIV) antibody was rejected by both the commissioners and the carrying woman.²⁶⁶ It is not known whether commissioned children are at greater risk of rejection than other children who are not reared by their birth mothers.

Children who are the result of paid arrangements will have to deal emotionally with the fact that they were actually purchased. Unlike most other children, who are usually born because of a relationship, these children are conceived because of a transaction. Even commissioners may speak of them in monetary terms: "People spend more on a Mercedes than we spent on Alexander";²⁶⁷ "It was a bargain worth every penny."²⁶⁸ Similarly, a broker said, "If a surrogate wanted \$100,000, well, to be real frank with you, I think a baby is worth \$100,000 ... But I would not use a woman if the figure was too high."²⁶⁹ Levin refers to "using a woman" as a means of production; the product is the child. Will the child be harmed by the knowledge of the price the commissioners paid? Will some babies have a "Saks Fifth Avenue price tag and [others] a K Mart price tag?"²⁷⁰

Research obviously must be conducted before we can understand the effects on commissioned children of the practice that brought them into being. It is possible they will suffer from not being reared by both, or all, of their genetic and gestational parents; from the fact or possibility of being rejected; and from the knowledge they were exchanged for money.

Harm to the Carrying Woman's Other Children

A preconception arrangement affects more than just the parties to it and the commissioned child. As in any family, relatives of the prospective child have an interest in the new life. The period of gestation and the birth undoubtedly have an impact on the carrying woman's other children, husband, and parents.

Two Ontario researchers, Dr. Jennifer Steadman, a psychiatrist, and Gillian Tennant McCloskey, a social worker, have recognized as clinical concerns the possible negative effects of a preconception arrangement on family members.

The system is a complicated one and involves all members of the "incubating family" and the child-rearing family. The people affected include the surrogate mother's husband whose thoughts, wishes, and perceptions have often not been considered, and the surrogate mother's children who were frequently ignored.²⁷¹

That the interests of the other children are seldom considered is clear from the fact that proponents of the practice often argue that carrying women should be only those who already have children.²⁷² As Bill Handel

has said, "We are not going to let anyone experience childbearing for the first time with *our children*" [emphasis added].²⁷³ The premise of the argument is that women who already have children will be familiar with the physical and emotional risks of pregnancy and are therefore less likely to change their minds about surrendering the children. But this argument is not usually further developed to consider how the mother's other children will be affected by the surrender.

According to one study, a child is capable, even at 18 months, of understanding that its mother is gestating a new life.²⁷⁴ Steadman and McCloskey argue that "increased abandonment anxiety is a distinct possibility in the children of surrogate families who see their parents willingly giving away children after birth."²⁷⁵ Children who experience sibling loss as a result of death,²⁷⁶ family breakdown, or child protection litigation tend to have serious depressive reactions.²⁷⁷

Literature on sibling perinatal loss recommends that the loss be acknowledged openly by the parents rather than denied. "If the loss is not accurately understood and resolved, deleterious effects can happen over time, as additional meanings and distortions occur ... [for example] the child may wonder, 'If this can happen to a baby, why not me?'"²⁷⁸

At least one brokerage firm advises carrying women to tell their children about what is taking place. Hanafin claims,

I'm adamant about not keeping your other children in the dark ... I'm of the school that we have to deal with this very cautiously, but that if we all pretend what happened didn't happen, we may be creating rather than avoiding psychological scarring.²⁷⁹

Andrews argues that psychological scarring can be avoided "if the children are told from the beginning that this is the contracting couple's child — not a part of their own family."²⁸⁰ Despite Andrews' advice, the fact is that at least for nine months the child is a part of their own family. Andrews claims nevertheless that an explanation will cause the children to "realize that they themselves are not in danger of being relinquished"²⁸¹ and cites as proof the case of Donna Regan. Regan told her child, "The reason we did this was because they [the commissioners] wanted a child to love as much as we love him."²⁸² Ironically, Regan is quoted elsewhere in a manner that casts doubt on Andrews' theory that an explanation will quell a child's fears of abandonment and desire for a sibling. Regan told the *New York Times* that her son, Steffyn,

is a gifted child and you cannot snow this kid ... Our main explanation was that we loved him very much and that we wanted Sherill and Bob to have a child they could love, too ... He immediately said, "You're not going to give them me, are you?" ... And we said, "No" and we had to start all over.

[When Steffyn was told that his mother was carrying twins for a second preconception arrangement, he] responded, "Fantastic, now you can give them one and we can keep one," his mother said. "So we had to explain it to him all over again."

Steffyn has recently started seeing a child psychologist Mrs. Regan said, but not because of her surrogacy. She said his behavioral problems stemmed from her inability to give him as much time as normal when she was pregnant.²⁸³

Thus, even if, as proponents recommend, the child or children are told the baby will be relinquished to another couple at birth, it is not clear that they will understand or be unharmed. Whereas loss by death is irreversible, inevitable, and natural, relinquishing a baby might be perceived as none of these by the other children. Carrying woman Nancy Barrass claims that the relinquishment has frightened her elder child:

My child bonded with this baby. She used to put a receiving blanket on my belly at night and say, "Night-night" ... She felt it kick and bonded with that. And now when I got home from the hospital, my daughter said to me, "Mommy, if I'm a bad girl, are you going to give me away?"²⁸⁴

The carrying woman's other children might be at risk also from the lobbying efforts of the commissioners. For example, one woman (mentioned above²⁸⁵) relinquished a child to commissioners who later wanted another. The carrying woman said that her oldest child, Chris, who remained with her, wanted "a baby brother of his own."²⁸⁶ The commissioning woman, Rhonda, decided to persuade the child.

Rhonda, who had spoken to Chris a number of times, asked for him to be put on the phone.

"I'll come to Amarillo and I'll take you to the toy store and buy you anything you want, anything," Rhonda told Chris.

"Okay, she can have another baby," he said.

Carol reports on the visit. "They went to the toy store together. I stayed home, cringing with terror, because she quite literally would have bought him anything," explains Carol. "He picked out a \$25 or \$30 G.I. Joe airplane. There were things in the store that cost \$400, \$500, and \$600 and my son only spent \$30. Maybe I was a little disappointed, I don't know, but I was so proud that he didn't try to wring her for all she was worth. That airplane was his pride and joy."

In May 1983, Carol conceived again with [Rhonda's husband's] sperm.²⁸⁷

This account does not report how the boy has coped with the fact that his parents put him, at the age of five, in a position to determine whether he would know his own stepbrother.²⁸⁸

Although carrying women often tell interviewers during the pregnancy or shortly after that they are confident their other children have not suffered, there is thus anecdotal evidence suggesting this may not be so. As Steadman and McCloskey state, "It would be naive to think that the children of the incubating family will be unaffected by loss."²⁸⁹

Harm to the Carrying Woman's Husband or Partner

In Lori Andrews' book, *New Conceptions, A Consumer's Guide to the Newest Infertility Treatment*, under the section entitled, "What to Look for in a Surrogate Mother," the author suggests that a "good candidate for surrogate parenting" is a woman with a stable home life and a "stable routine with husband and family to return to once the pregnancy [has] ended."²⁹⁰ She (ironically, given their later regret and misgivings)²⁹¹ cites the cases of Elizabeth Kane and Carol Pavek, arguing that these are good candidates because they had husbands and children. But she does not consider the effect of the agreement on the carrying woman's partner and their relationship.

Although there is no research on the subject, it is likely that the partner of the carrying woman is affected by the arrangement. Like the partner of any other pregnant woman, he must make accommodation for the physical and psychological changes that the woman experiences. When the child is the man's own, his interest in adapting to her changed circumstances is usually great.²⁹² When she is carrying the child of another man, it is possible that he will feel excluded, resentful, and jealous. Research on donor insemination suggests that "problems can arise for him in the sexual area beginning with a feeling that 'adultery' has occurred upon his wife's insemination."²⁹³

There is anecdotal evidence that a preconception arrangement has the potential to have serious negative effects on the partner and the relationship. Susan Downie, an Australian researcher, found that carrying women had many stories of difficulties.

One American woman tells how her fiancé left her for another woman, another said her husband could not look at her after she was inseminated. "He calls me a whore, prostitute and rent-a-womb." One commented, "My husband first felt it threatened his manliness." Another said, "His attitude has turned against me. We're hardly having any sex at all now," and one reported that her husband wished she had never become involved in surrogacy and that their sex life was nonexistent.²⁹⁴

Direct interference with marital relations is entailed by Handel's firm's requirement that the carrying woman "abstain from sex from approximately two weeks before the first insemination attempt until pregnancy is achieved, and that can be many months."²⁹⁵ The psychological impact of this form of interference with the relationship of husband and wife might be great, though data are not available. The foregoing anecdotal evidence, however, suggests that a preconception arrangement can have significant negative effects on the relationship between the carrying woman and her partner.

Harm to the Carrying Woman's Parents

Although, again, there are no studies on the subject, it appears from personal accounts that the parents of the carrying woman suffer because they have a grandchild whom they cannot grow to know and love.²⁹⁶ Moreover, they might disagree with their daughter's decision to participate, which might itself lead to intrafamilial tension.

Harm to the Commissioning Woman

As described above,²⁹⁷ it is apparent that in the most common arrangement, which involves insemination, the commissioners benefit in unequal ways: the commissioning man receives his genetically related child from the transaction; the commissioning woman (if any) receives a genetic stranger to her. A commissioning woman who received two children from two different carrying women who were artificially inseminated described her husband's experience thus: "He had a wonderful time. He has two different women, two different babies. Three women altogether. He's doing all right."²⁹⁸

A commissioning woman may have ambiguous feelings, even though, according to one carrying woman, such arrangements ought to satisfy her: "She has the advantage of raising her husband's children; what more could a woman want than to raise her husband's children?"²⁹⁹

The fact that the commissioning woman is unrelated to the child may create problems, as the child may become a symbol of her perceived inadequacy and the ability of another woman to do what she could not.³⁰⁰ According to one commentator,

[Commissioning] women often feel that they are giving a gift to their husband, instead of fulfilling their own desire to have children. The woman may be forced by external pressures such as a "lack of alternatives to child-rearing", "fear of social ostracism", and fear of "emotional and economic abandonment by her husband."³⁰¹

Some women are, in fact, reluctant to enter into the arrangement; for example, one woman who commissioned a child did so only after considerable pressure from her husband:

John would not drop the subject, and I soon realized that I had underestimated his desire to have another child. [She could not conceive again after delivering a boy.] He continued to bring home articles on the subject of surrogate mothers ... But the idea was so distasteful to me that I could hardly bring myself to read the material. I was bitterly resentful that John would even consider having a child with another woman — which was, after all, what surrogate parenting was all about.³⁰²

Even after she and her husband left the broker's office she "still had mixed feelings about what we were doing."³⁰³ Eventually they received a girl, the daughter of her husband and a carrying woman. The account does not discuss how this experience affected their marriage and whether the commissioning woman relates differently to this child than to her son.

The difference in the commissioning woman's relationship to the child might become painfully apparent in the event of marriage breakdown, particularly if she has not formally adopted the child. In the California cases involving a commissioning 35-year-old man and his 51-year-old wife, joint custody of the 15-month-old girl was awarded to the commissioning man and to the carrying woman who had not signed adoption papers to relinquish the child. The commissioning woman was granted no visitation rights. According to Judge Nancy Wieben Stock, the commissioning woman

is the one most victimized by the present circumstances ... [she] has experienced the most profound losses a human being can experience all within the span of 16 months. She has lost her child, her husband, her family.³⁰⁴

These accounts, and those related above (in criticizing the view that the carrying woman helps primarily the commissioning woman³⁰⁵), suggest that the benefits to the commissioning woman are ambiguous.

Potential Harm to Society

The practice of commercial and paid preconception arrangements transforms procreation into production by radically altering the context in which conception occurs. What has, in the past, usually taken place privately and because of an intimate relationship is now initiated by a transaction, the terms of which are that a woman shall conceive by use of mechanical instruments in a clinical setting and surrender the resulting child. The producer, assisted by the technologists, is expected to deliver the desired product according to specifications. In this way, pregnancy becomes a paid service and the child a product. The potential negative consequences for society of this commodification of pregnancy and children are great.

In the first instance, the very point of the transaction is to deny the primary relationship between mother and child, and to suggest that relinquishing a commissioned child is merely a matter of fulfilling an agreement. One potential consequence of this is the continuing notion that the child is a product that exists independently of relationships. This notion appears to have motivated a judge in the custody battle between the Ohio commissioners over Tessa Reams to contemplate that she be awarded, not to the carrying woman or either of the commissioners, but to "an unidentified East Coast couple reported to have a six-figure annual income."³⁰⁶ The commissioning woman, who had been raising the child for four years, said, "The judge concentrated on how much these people could give Tessa ... I feel like I'm in a bidding war over this kid, and I am the low bidder."³⁰⁷ Thus, once it is considered permissible that a child should be conceived specifically for alienation from its mother, it apparently becomes easy to view the child as further alienable — like a transferable item, rather than as a person growing within a web of relationships.

A second aspect of the commercialization and commodification of childbearing is that the market will inevitably continue to attempt to

increase supply until it meets demand. One method is to recruit carrying women from among the young. As discussed above,³⁰⁸ Noel Keane is already doing this with his video, *A Special Lady*, which, according to Janice Raymond, is shown in high schools. Another method to increase supply is to recruit minority women. The advent of embryo transfer means women impregnated in this way make no genetic contribution to the child. This technique substantially increases the range of potential suppliers for the largely white and more affluent market to include non-white women as gestators. The new technology eliminates the "need" for "the barrier of racism that might have kept whites from using Black and Hispanic women as surrogates."³⁰⁹ A broker might also recruit carrying women from abroad, for example, as a broker, John Stehura, told Gena Corea:

"We're bringing girls in from the Orient," he said. "From Korea, Thailand and Malaysia." (He was also exploring the possibility of initiating some pregnancies in those countries and bringing just the babies to the United States, he said.)³¹⁰

Under Stehura's plan, the woman would not be paid. The commissioners would pay her travel and living expenses in the United States. The women would benefit from the arrangement despite the lack of remuneration because "they're looking for a survival situation — something to do to pay for the rent and food." In their home countries "food is a serious issue."

A third possibility arising from the commercialization of procreation is that brokers will attempt to extract a higher "yield" from carrying women. Some such women, as we have seen, refuse to relinquish the children. One method to ensure a 100 percent yield is by state screening and state-enforced relinquishment. The OLRC recommended that the court should screen each prospective carrying woman by assessing her physical and mental health, her marital and domestic circumstances, the opinion of her spouse or partner, if any, and the likely effects of participation on existing children under her care.³¹¹ It is not clear what criteria the court would use to make these assessments. The ABA [American Bar Association] Model Surrogacy Act would also require that prospective carrying women be screened to ensure they are physically healthy, disease-free, and "mentally and emotionally capable of entering into a surrogacy agreement."³¹² Only women who passed these tests would be permitted to enter into an agreement. Whether a carrying woman would be able or willing to fulfil the agreement is another question, the answer to which would be irrelevant under both proposals because by invoking the contractual remedy of "specific performance," the state, at the instance of the commissioners, would take the child from her at birth.³¹³ As one commentator described this legislative policy, "Regulation is a baby-broker's dream ... [it] is designed to protect the brokers' interests first, and after that, the sperm donors."³¹⁴

High yield can be ensured also by simply preventing the occasion from arising where a woman would try to keep the child. We have quoted

instances in which brokers used threats and intimidation in a effort to ensure compliance, and monitored carrying women by requiring their attendance at monthly meetings.³¹⁵ Handel, for example, requires that carrying women keep him informed of their whereabouts at all times because

she's carrying my client's child. It's nice to know where she is at all times. If she moves, we have to know. If she changes employers or insurance, we have to know. If anything traumatic happens in her family such as a death or a job loss — anything that could materially affect the contract in any way whatsoever — we have to know. If anything comes up, we deal with it. She breaches the contract if she does not tell us.³¹⁶

To ensure a high yield, Handel monitors carrying women carefully. If the practice of preconception arrangements continues to develop as a commercial enterprise, methods of surveillance might become more intrusive and we might expect further radical changes in the manner by which society views the relationship of mother and child and the value of human procreation.

Conclusion

This part has demonstrated that the common depiction of preconception arrangements is inaccurate in that it presents an incomplete and misleading picture of the total range of participants' characteristics and desires. Moreover, the common depiction takes no or insufficient account of the interests of third parties in promoting the practice, and of the actual and potential harms to persons affected by the arrangements. A more comprehensive approach suggests that the practice of preconception arrangements is based on a market model that transforms procreation into production and threatens to increase the harm potentially caused by the practice to affected persons and to society.

Despite its serious limitations, the common depiction of preconception arrangements is, in general, assumed to be true by proponents of the practice. For this reason, among others, their arguments in favour of preconception arrangements are of questionable merit. To these arguments we now turn.

Part 4. Proponents' Arguments and Their Premises

Introduction

With a more complete picture of the practice of preconception arrangements, we are now in a position to examine the arguments of proponents of the practice. As this part will demonstrate, these arguments rely upon the incomplete and misleading common depiction, and they are

internally inconsistent. More significantly for the development of legislative policy, they are based on the false premise that procreation can be described by a market production model and that contract law is best suited to govern the practice. For these reasons, proponents' arguments give rise to legislative proposals that would precipitate many of the harms identified in the preceding part of this report. This part concludes by arguing that, to develop legislative policy, we must search for and rely on a wholly different theoretical approach to procreation.

A Consideration of Proponents' Arguments

The arguments for preconception arrangements can be categorized by their central emphases: rights, medical treatment, liberalism, and market efficiency. The first two focus on demand, the third on supply, and the fourth on the union of demand and supply in an efficiency-driven market context. We examine these in turn.

The Rights Argument

John A. Robertson, a law professor at the University of Texas, is the foremost exponent of the view that there exists, in the United States, a constitutional right to "procreative liberty," understood as the freedom to participate in one or more of three aspects of reproduction, which he identifies. According to Robertson, this alleged right establishes and protects the freedom to participate in a preconception arrangement. In his view, the state may not limit participation in preconception arrangements unless it can demonstrate that such participation would cause tangible harm, of which Robertson claims there is little evidence. As shall be made clear, however, Robertson's argument is flawed in at least three ways. The U.S. Supreme Court cases upon which he relies do not support his claim that there exists a constitutional right to participate in a preconception arrangement. Secondly, his understanding of human procreation and its attendant responsibilities is open to question. Thirdly, his assessment of the potential harms of participation is based on the common depiction of preconception arrangements and is, therefore, incomplete.

Robertson begins his constitutional argument from the uncontroversial premise that, in the United States, married couples have a right to reproduce by sexual intercourse. He acknowledges that there are no cases that explicitly establish or recognize this right, but he claims nevertheless that "in dicta, ... the Supreme Court on numerous occasions has recognized a married couple's right to procreate in language broad enough to encompass coital, and most non-coital, forms of reproduction."¹ Relying on the well-known line of U.S. Supreme Court cases concerning reproductive privacy beginning with *Meyer v. Nebraska*² and including *Skinner v. Oklahoma*³ and *Stanley v. Illinois*,⁴ Robertson claims that

If the Supreme Court would recognize a married couple's right to coital reproduction, it should recognize a couple's right to reproduce noncoitally as well. The couple's interest in reproducing is the same, no

matter how conception occurs, for the values and interests underlying coital reproduction are equally present.⁵

More emphatically, he asserts:

Two points that have great significance for the new reproductive technologies follow from constitutional acceptance of a married couple's right to reproduce coitally. First is the right of the married couple to reproduce non-coitally as well, through such means as artificial insemination with the husband's sperm or through extracorporeal fertilization — the IVF process. Second is the right to reproduce non-coitally with the assistance of donors and surrogates.⁶

In other words,

Because there is a constitutional right of infertile couples to reproduce by non-coital means that extends to the use of surrogates. This means that the state cannot criminally ban either the use of surrogate arrangements or the payment of money to surrogates.

This also means the contract cannot be declared void on public policy grounds and must be legally enforced, at least by damages.⁷

Yet Robertson fails to establish that there is a constitutional right in the United States to participate in a preconception arrangement. For reasons of constitutional legal analysis detailed in Appendix 1,⁸ the holdings in the Supreme Court cases upon which Robertson relies are insufficiently broad to substantiate his claim of the existence of such a right.

Moreover, his argument does not demonstrate that the right *ought* to exist. Robertson argues that, because married persons are free to have children by sexual intercourse, a man or a couple ought to have the right to hire a woman to become pregnant, and then to take the baby from her at birth. Robertson claims that the second right ought to follow from the first because the interests that fertile and non-fertile persons have are the same.

Coital infertility does not render a couple inadequate as child-rearers. The values and interests that undergird the right of coital reproduction clearly exist with the coitally infertile. Their interest in bearing, begetting, or parenting offspring is no less than that of the coitally fertile.⁹

That might be so, but it does not follow that, because one has an interest in having what one's body is incapable of providing, one has a right to have it. For example, persons dying of kidney or heart disease presumably have an interest in continued life that is as great as that of healthy persons. If Robertson's reasoning were correct, dying persons could claim that their interest in continued life grants them a right to non-interference by the state in their attempts to buy kidneys or hearts from willing sellers. But, as the Supreme Court of New Jersey held when it denied the existence of a constitutional right to participate in preconception arrangements,

There are, in civilized society, some things that money cannot buy ...
There are, in short, values that society deems more important than
granting to wealth whatever it can buy, be it labor, love, or life.¹⁰

For these reasons, and those detailed in Appendix 1, Robertson fails to demonstrate either that there is or that there ought to be recognized by the U.S. Constitution a right to participate in a preconception arrangement.

Not only does Robertson's argument fail by being based on a constitutional right that does not exist, but the argument is grounded in a curious notion of human reproduction and its attendant responsibilities. He views reproduction as consisting of three types of experiences that are distinct both conceptually and in terms of their significance to individuals, *viz.*: "conception, gestation and labor, and childrearing."¹¹ According to Robertson, "each of [these] has personal value and meaning independently of the others."¹² He claims that an individual might have an interest in having an experience of only one or two but not all three aspects of reproduction. For example, "men and women may want the satisfaction of transmitting their genetic heritage without taking on the responsibilities of gestation or rearing."¹³ With regard to the second component of reproduction — gestation and labour — Robertson claims, "some women find enormous satisfaction and significance in pregnancy and childbirth, even if they never see or rear the child."¹⁴ So, too, does the third component of reproduction have independent value. In Robertson's view, "childrearing is a rewarding and fulfilling experience, deserving respect whether or not the person who rears also provided the genes or bore the child."¹⁵ Thus, Robertson believes that "each aspect of reproduction can ... be a separate source of fulfillment and significance closely related to that provided by the other aspects."¹⁶ As a consequence, "Procreative freedom includes the right to separate the genetic, gestational, or social components of reproduction and to recombine them in collaboration with others."¹⁷

Among the surprising results of such a view are how it would fracture the experience of procreation and how it would limit the duties that parents owe to each other and to their children. To describe human reproduction as consisting of three separable and interchangeable component parts is to misdescribe it. When the process of procreation occurs naturally, it involves at least 12 aspects: menstruation, ovulation, spermatogenesis, copulation, alienation of male gametes by ejaculation, conception, gestation, labour, birth, appropriation of the child, lactation, and nurture.¹⁸ Of these 12 aspects, men participate directly in five (spermatogenesis, copulation, ejaculation, appropriation of the child, and nurture), whereas women participate directly in all but two (spermatogenesis and ejaculation — and even the latter takes place inside women's bodies). Given that human reproduction thus involves for women a prolonged and continuous experience, which profoundly affects them physically and (usually also) psychologically, it is odd that Robertson should describe it as a series of (only) three disconnected experiences that have independent but not

necessarily derivative value. Moreover, Robertson's description of the first component of reproduction can be used to justify not only the activity of a sperm donor in aiding an infertile couple, but also that of a man whose sexual activity makes a woman pregnant but who then decides not to assist her. Such men could rely on Robertson's argument to substantiate the moral legitimacy of their desire to have "the satisfaction of transmitting their genetic heritage without taking on the responsibilities of gestation or childrearing."

This raises the issue of what are the duties to which the alleged "right to separate the genetic, gestational, or social components of reproduction"¹⁹ gives rise. In Robertson's view, a person has only those duties related to the specific reproductive right that he or she has chosen to exercise. Therefore, unless one chooses a reproductive experience, one has no duties. But if one does choose to exercise a reproductive right, one is solely responsible for its proper exercise. For example, if persons choose to rear, they must do so in a manner that ensures the well-being of the child. Robertson would permit the state to take children from their rearers where the rearers are manifestly unfit.²⁰ Similarly, if a woman chooses to gestate (in the sense that she does not abort in the first trimester), then she must conduct her life in ways that will not injure the fetus. Robertson would permit states "to punish a woman who refused to take a necessary medication (as, for example, a diabetic mother who failed to take insulin)."²¹ Robertson views duties arising from reproductive rights as owed exclusively to the fetus or child, and only to the extent that one has chosen to exercise the right. Consequently, he would find that a man who chooses only to pass on his genes has no duties either to his child or to, for example, the diabetic mother of his child who is in need of funds to buy insulin.

In addition to relying on a constitutional right that does not exist, and a curious notion of reproduction and a morally questionable understanding of its attendant responsibilities, Robertson insufficiently appreciates the potential harm that preconception arrangements can cause, and the role of the state in preventing the harm.

Because Robertson believes that "there is a strong case for a constitutional right to employ a surrogate,"²² he believes that the state may not limit persons' exercise of that right without first discharging the burden to prove a compelling state interest. What counts as a compelling state interest? Robertson contemplates and discounts four: harms to commissioners, to carrying women, to commissioned children, and to society generally.

Robertson states that commissioners might be harmed physically or psychosocially by (*inter alia*) participating in a preconception arrangement. The harms could arise from "medical and surgical procedures" and "the guilt, stigma, or conflict that the couple may feel in tampering with nature or involving another person in their reproduction."²³ Similarly, the harm to carrying women might "also be significant" for they "may experience physical harm through the risks of pregnancy and childbirth and

psychological harm through relinquishing the child.”²⁴ Given these possible harms to participants, what form of legislative response does Robertson envision?

A state could institute regulations designed to inform the collaborators of the consequence of their participation in the procreative process, regulations preserving their anonymity, and regulation (such as licensing requirements) to protect their health and safety.²⁵

In other words, Robertson envisions only a regulatory role of the state, believing that persons are entitled to be free to make reproductive choices. He does not consider the full range of potential harms for participants identified in Part 3, nor that one of the potential harms of the practice is exploitation of the women involved. According to Robertson,

the state's interest in saving mature adults from the folly of their own choices would not justify total prohibition of collaborative conception, and the state arguably could not prohibit persons from paying reproductive collaborators.²⁶

Nor does Robertson believe that harm to the commissioned child is sufficient to justify state prohibition of the practice. In his opinion, the potential physical harm of IVF and the psychological harm of the knowledge of one's unusual conception are more speculative than real.

A higher incidence of birth defects in ... offspring would not justify banning the technique in order to protect the offspring, because without these techniques these children would not have been born at all. Unless their lives are so full of suffering as to be worse than no life at all, a very unlikely supposition, the defective children of such a union have not been harmed if they could not have been born healthy.²⁷

Here Robertson makes a logical error. In assessing preconception arrangements, the question for legislators is whether the practice is a justifiable method of bringing children into the world. Robertson's claim that children are better off if they are born because of preconception arrangements than they would be if they were not born at all assumes the very question at issue, *viz.*, whether children ought to be born in this way.

Likewise, Robertson's argument is flawed in its claim that the risk of psychological harm to offspring is “insufficient to justify restricting the fundamental right to procreate.”²⁸ According to Robertson,

There is no evidence that a child who knows he has been deliberately conceived by one person for the sake of another, or gestated by one person with another person's egg or sperm, would suffer any more than a child who knows he is adopted.²⁹

This argument is weak in two ways. First, as has been discussed in Part 1, there are no studies of the long-term effects of preconception arrangements on any of the persons affected by them.³⁰ We simply do not know whether the practice is harmful to commissioned children. Without studies, the absence of *evidence* of harm does not prove the absence of *harm*. Secondly,

the comparison with adoption is inapposite because (as discussed in Part 3), whereas adoption is a solution to an unintended conception, preconception arrangements *intend* a conception that shall separate the child from its mother. Therefore, from the point of view of legislative policy, the two practices are relevantly different.

Robertson may be criticized also for failing to consider the effects of the practice on other persons: the carrying woman's other children, her husband or partner, and her parents. These persons are significantly affected by the arrangement and have interests that must be assessed in determining the proper response of the state.

The final harm that Robertson does consider — harm to society generally — he dismisses in a curious way. He calls this type of harm "symbolic harm": it is the concern that "non-coital reproduction will confuse family lineage and blur the meaning of the family"³¹ and the belief "that it simply is wrong to engineer conception or to pay another for reproductive services."³² He does not seriously consider whether this "symbolic harm" results in exploitation and, in particular, exploitation of women, or in harmful changes to the way society views human procreation. He claims that "the main concern [about preconception arrangements] appears to be a desire to prevent symbolic harm to deeply felt notions of motherhood and the importance of the gestational bond."³³ To the extent that this harm occurs, it is, in Robertson's opinion, the fault of the women who become pregnant. Oddly, he discounts the role of the brokers and the commissioners, and instead condemns only carrying women for "treating the gestational bond as something to be manipulated and used for selfish purposes — the willingness to gestate a child and then coldly detach oneself from it."³⁴ According to Robertson, the conduct of such women "may be highly distasteful,"³⁵ but distaste is an insufficient basis for public action that would limit the procreative choice of willing parties. With this limited understanding of the harms and potential harms caused by the practice, Robertson claims that mere "symbolic harms" should not override "the couple's right to procreative liberty and a woman's right to find procreative meaning by serving as a surrogate gestator."³⁶ Thus, even though Robertson concedes that tangible harm could justify state interference in preconception arrangements, he inadequately assesses the harms that he considers, and he does not consider at all the harms caused to the carrying women's other children, partner, and parents.

Although Robertson has been a prolific proponent of a constitutional right in the United States to participate in and to enforce preconception arrangements,³⁷ his argument cannot be sustained because it fails to establish the existence of the constitutional right on which it is based, it relies on a curious understanding of the process of human procreation and a morally questionable appreciation of its attendant duties, and it insufficiently evaluates the extent of the harm actually and potentially caused by preconception arrangements and therefore the proper role of the state in preventing such harm.

The Argument of Medical Necessity

A second general argument of proponents shares Robertson's almost exclusive concern for commissioners but does not focus on a right to participate in a preconception arrangement. The argument of medical necessity holds that preconception arrangements can be justified as medical treatment for commissioners. The argument is espoused by, for example, the OLRC³⁸ and the Ethics Committee of the American Fertility Society (AFS).³⁹ This argument is open to criticism on at least three grounds. First, it does not provide adequate criteria to determine who may and may not participate in the "medical treatment" that is the preconception arrangement. Second, it does not take into account or justify that while all the risks and pain of pregnancy and parturition are borne by the carrying woman, all the benefit accrues to the commissioners. Third, it fails to demonstrate how participation is medically related.

Both the OLRC and the AFS view participation in a preconception arrangement as a privilege that derives from a medical need, rather than as a right. For the OLRC, the practice is justifiable because "in the context of surrogate motherhood ... recourse to medical means of alleviating the effects of infertility or genetic impairment cannot conscientiously be forbidden."⁴⁰ The AFS similarly considers participation necessary for persons requiring "medical treatment" when they have "indications" such as the inability to gestate because of the absence or malformation of the uterus, or severe hypertension.⁴¹ Both committees are adamant that the privilege should not accrue to a woman who prefers "not to disrupt other endeavours, such as a career, or who [wishes] to avoid the physical effects of pregnancy."⁴² These "reasons of convenience" are insufficient because, according to the OLRC,

Our sole purpose in allowing individuals to pursue surrogate motherhood arrangements under strict control is to respond to infertility, not to afford individuals the opportunity to satisfy their lifestyle preferences.⁴³

According to the AFS, "reasons of convenience or vanity" are insufficient to justify participation because they, *inter alia*, create "speculation that a woman's refusal to carry the pregnancy calls into question her ability to care for the child after its birth."⁴⁴

Yet these criteria for granting the privilege of participation on the one hand, and denying it on the other, are insufficiently determinative and illogical.

Consider, for example, a case where a commissioning man wishes to participate in an agreement because he has married either a post-menopausal woman⁴⁵ or a woman who, having had three children in an earlier marriage, voluntarily underwent a tubal ligation.⁴⁶ In such cases, is the man's desire to hire a woman to become pregnant with his child a response to infertility or is he attempting to satisfy a lifestyle preference? The criteria provided by the OLRC are not adequate to determine who ought to be granted the privilege of participation.

Moreover, it is illogical that a commissioning woman's decision not to become pregnant for career reasons should call into question "her ability to care for the child after its birth," whereas a commissioning woman's decision to protect her frail health by avoiding pregnancy does not raise the same concern. Indeed, in the first case, the commissioning woman might be well positioned to care for a child because, unburdened by the pregnancy and delivery, she might be healthy and rested when the newborn arrives, and the financial remuneration of her career would provide resources for the child's adequate care. By contrast, a commissioning woman suffering from "a serious heart condition"⁴⁷ or "severe hypertension"⁴⁸ — all "medical indications" for participation — might be too ill to care adequately for the commissioned child. Thus, on the basis of the best interests of the child, the AFS would illogically grant seriously ill women, but deny healthy women, the privilege of agreeing to rear a commissioned child. Further, the committee appears not to question whether a commissioning man's desire to have a genetically related child despite his wife's serious illness is, in itself, a desire prompted by reasons that the AFS condemns as "reasons of convenience or vanity."

A second criticism of the argument of medical necessity is that it neglects to provide any justification for the fact that all the medical risks and pain of pregnancy and parturition are borne by the carrying woman and yet all the benefits accrue to the commissioners.

Both the OLRC and the AFS claim that this discrepancy in the allocation of "treatment" burden and benefit can be justified in the same way as we justify *inter vivos* organ donation. According to the OLRC, "We do not find [organ donation] offensive to fundamental values, even though, in the case of a kidney transplant, the donor may be taking a risk, since the remaining kidney may later fail."⁴⁹ According to the AFS, "Just as society approves of organ donations to save lives, here there is a functional donation to foster a potential life."⁵⁰

But the analogy is not apposite; there are important differences between organ donation and preconception arrangements. Unlike renal failure, infertility is not life-threatening. Unlike the case of organ donation where the donor is, by definition, unpaid,⁵¹ both the OLRC⁵² and the AFS⁵³ foresee that carrying women would be paid. Unlike the case of organ donation, where a donor might withdraw consent at any time up until the operation to remove the organ, the carrying woman under both the OLRC and the AFS proposals would be compelled to surrender the infant.⁵⁴ Finally, and most significantly, whereas an organ is merely a body part, a child is a human being with whom a woman develops a relationship in the process of nurturing and giving birth to it.⁵⁵ It is misguided to argue that the relationship of a kidney donor to one of his or her kidneys is similar to that of a mother to her child; kidneys are fungible, children are not. For these reasons, arguments that might justify organ transfer to save a life are simply irrelevant to the practice of preconception arrangements, which purport to conceive a human being for transfer from its birth mother to

commissioners, not to save their lives but to fulfil their desire for a genetically related child.

The striking disparity in health risk and benefit brings us to the third criticism of the argument of medical necessity: that the practice of preconception arrangements does not constitute medical treatment. The AFS states, "the primary reason for the use of surrogate motherhood [by artificial insemination] as a reproductive option is to produce a child with a genetic link to the husband."⁵⁶ If this is the goal of the practice, do the means to achieve this goal constitute medical treatment? To this question, both the OLRC and the AFS would answer yes. In their view, preconception arrangements are "medical means"⁵⁷ and a "medical solution."⁵⁸ But their view is open to question.

For a procedure to be characterized fairly as "medical treatment," arguably it must, at minimum, be performed on the person who suffers from disease or impairment, and it must aim to cure the disease or remedy the impairment, or to alleviate the symptoms of the disease or impairment. By this definition of "medical treatment," however, neither artificial insemination nor embryo transfer in the context of preconception arrangements constitutes medical treatment. That this is so can be demonstrated by examining each case in turn.

Consider, first, the case of artificial insemination of a carrying woman. Is it performed on a person who suffers from disease or impairment? The answer is no. The insemination procedure is performed on the carrying woman, who does not need medical aid to become pregnant. Because she is fertile, she might more easily become pregnant simply by having sexual intercourse with the commissioning man. If she chooses not to do that, she can achieve the same result by inseminating herself with the commissioning man's sperm. Therefore, the procedure that the OLRC and the AFS consider "medical" is unnecessarily performed on a healthy woman. Who, then, is the patient and what is the disease? According to the OLRC and the AFS, the commissioning woman suffers from impaired fecundity, which necessitates the "medical" intervention. But neither the OLRC nor the AFS explains why the commissioning woman, the person with the impairment, is not the subject of the "medical" procedure. Moreover, they do not distinguish between commissioning women with medical problems and those without—for example, commissioning women who have ceased menstruating as the natural result of the aging process.

Further, the procedure of artificial insemination does not aim to remedy the commissioning woman's impaired fecundity. Even if the procedure, once performed on the carrying woman, results in the birth of a child that the commissioning woman will raise, the commissioning woman remains infertile.

It might be argued, however, that the activity of inseminating a third party *does* constitute medical treatment because (though conducted on a woman who is not the patient) it alleviates the *symptoms* of the patient's impaired fecundity.

To examine this argument, we must establish what are the symptoms of impaired fecundity that, if treated, would render the treatment medical. On a narrow definition of "symptom," the symptoms of impaired fecundity might include a disruption of a bodily process such as amenorrhoea or anovulation, or a defect in a reproductive organ such as a blocked fallopian tube. But the OLRC and the AFS do not confine themselves to this narrow definition of the symptoms of impaired fecundity. The OLRC recommends that Ontario recognize the practice and legally enforce the agreements to alleviate childlessness:

[T]he majority of the Commission is of the view that recourse to medical means of alleviating the effects of infertility or genetic impairment cannot conscientiously be forbidden. It does not see the endorsement of this practice as foreshadowing the dissolution of the family, nor does it accept that only harm can come to the child or children involved. Indeed, by assisting an otherwise childless couple, surrogate motherhood may be the sole means of affirming the centrality of family life.⁵⁹

The AFS believes the practice is medically "indicated," not only to alleviate childlessness but also to alleviate a second symptom of impaired fecundity: unhappiness in, and the threat of dissolution of, the commissioning couple's relationship. According to the AFS,

The use of a surrogate mother allows the infertile woman who wishes to rear a child the opportunity to adopt an infant more rapidly than by waiting several years for a traditional adoption. In addition, it allows her to rear her husband's genetic child.

For the husband of an infertile woman, the use of a surrogate may be the only way in which he can conceive and rear a child with a biologic tie to himself, short of divorcing his wife and remarrying only for that reason or of having an adulterous union. Certainly, the use of a surrogate mother under the auspices of a medical practitioner seems far less destructive of the institution of the family than the latter two options.⁶⁰

Clearly, the AFS believes that among the symptoms of impaired fecundity are childlessness and the possible dissolution of relationship between wife and husband or between partners. Thus, both the OLRC and the AFS justify the participation of physicians on the basis that the intervention of medical practitioners might alleviate the potential social effects of the impairment.

This adherence to a broad definition of the "symptoms" of impaired fecundity to include the social effects of the ailment has significant consequences. If childlessness and the possibility of dissolution of a relationship are symptoms of disease or impairment, and the treatment of these symptoms constitutes medical treatment, then adoption and marriage counselling are medical treatment.

Clearly the response to the social effects of disease and impairment, even the response of physicians, is not, for that reason, medical treatment.

In the context of preconception arrangements, there is a distinction to be made between, on the one hand, the treatment of a disruption of a bodily process or defect, and on the other, the treatment of the *social effects* of the disruption or defect. Though both treatments might be applauded as conscientious efforts to reduce suffering, only the first (and provided it is performed on a diseased or impaired person) can properly be considered medical treatment. It is important to distinguish between medical practices, such as treating amenorrhoea or repairing a damaged fallopian tube, and social practices, such as adoption and preconception arrangements. This distinction is important to the development of coherent social and legislative policy because the justifications for, and in Canada the methods of financing, most medical practices are different from the justifications for and methods of financing social practices.

Nor is it correct to understand the second form of preconception arrangements as medical treatment. The procedure of embryo transfer involves artificial hormonal stimulation of, and egg extraction from, the commissioning woman; fertilization of the egg in a glass dish; and then the transfer of the embryo into the carrying woman. In this second form of preconception arrangement, therefore, and unlike the first, some of the practitioner's activities are actually conducted on the body of the person who might be impaired, *viz.*: the commissioning woman. But embryo transfer cannot be considered medical treatment, because it fails to meet the second criterion: it aims neither to remedy the impairment nor to alleviate its medical symptoms (properly defined). Like artificial insemination of a carrying woman, embryo transfer aims to alleviate only the social effects of the commissioning woman's lack of fecundity.⁶¹ Also like artificial insemination, and under the guise of "medical treatment," the carrying woman assumes the risks of pregnancy and parturition without commensurate health benefit to herself.

Because, therefore, the procedures of artificial insemination and embryo transfer in the context of a preconception arrangement are not performed on the commissioning woman to cure a disease or remedy an impairment, or to alleviate her symptoms (if any) of bodily disruption or defect, the procedures, despite the participation of physicians, do not constitute medical treatment.

Thus, the argument of medical necessity fundamentally mischaracterizes preconception arrangements. With indeterminate and illogical criteria, proponents of the argument would countenance the subjection of a healthy woman to physical and psychological risks without commensurate health benefit to herself to fulfil the desire of commissioners to have a genetically related child. Proponents claim that this activity constitutes medical treatment. Yet, in attending to social issues (the desire for a[nother] child and the threat of a relationship's dissolution), the primary motivation for the practice is not medical. What is more, the practice of working on a third person's healthy body, seeking neither to cure nor to remedy the *patient's* disease or impairment (if any), is not

medical. For these reasons, the argument of medical necessity is inadequate to justify the practice of preconception arrangements.

The Liberal Argument

A third general argument advanced by proponents of preconception arrangements focusses not on demand but on supply. It holds that a carrying woman is entitled to do with her body as she pleases; to restrict her would unjustifiably limit her autonomy and freedom. From the premise that freedom is an ultimate value, the liberal position attempts to justify a woman's unconstrained liberty to enter preconception arrangements. The argument has also been used to justify the act of state enforcement of the agreement should she subsequently wish to keep the child.

It is useful to articulate the political premises on which proponents base their view that women ought to be free to participate in state-enforced preconception arrangements. One premise is a commitment to an ideal of liberty in areas of personal life, for example, with regard to sexual practices, marital relations, and reproductive decisions; a second premise is a commitment to an ideal of equality between men and women; and a third stems from commitment to an ideal of economic liberty and the freedom to contract.⁶² While it is useful to isolate these three premises, it is not suggested that proponents necessarily rely on one to the exclusion of the others.

Larry Gostin, executive director of the American Society of Law and Medicine in Boston, bases his argument on the first premise. He claims there is a constitutional right to privacy and autonomy that protects the freedom to participate in a preconception arrangement.⁶³ Yet as is demonstrated in Part 8 and Appendix 1 of this work, neither Canadian nor American constitutional law would recognize such a right. Independently of the law, however, it is philosophically inconsistent to argue that a woman has a privacy right to enter into a commercial arrangement. As we have seen, a preconception arrangement is not concerned with sexuality, sexual intercourse, or intimacy. On the contrary, preconception arrangements tend to be commercial transactions that function according to the norms of industry so that the justification of participation in a commercial, paid preconception arrangement cannot be based on arguments related to intimacy and privacy. Gostin himself recognizes that an argument based on freedom of intimate association could not be used to enforce agreements.⁶⁴ Thus, neither the practice of preconception arrangements nor (as Gostin himself concedes) their specific enforcement can be justified by an argument from freedom of privacy and intimate association.

Commitment to an ideal of gender equality is the basis for a second argument for freedom to participate in preconception arrangements. Lori Andrews, a legal research fellow at the American Bar Foundation in Chicago, views such arrangements as having the potential to liberate women from the sexist assumption that "biology is destiny." Preconception arrangements are, according to Andrews, "a predictable outgrowth of the

feminist movement.”⁶⁵ Because the feminist movement encouraged women to postpone childbearing to pursue educational and career opportunities, and to use certain contraceptive devices, both of which compromised their fertility, “some of these women found that the chance for a child had slipped by them entirely and *needed* to turn to a surrogate mother” [emphasis added].⁶⁶ On the supply side,

Feminism ... made it more likely for other women to feel comfortable being surrogates. Feminism taught that not all women relate to all pregnancies in the same way. A woman could choose not to be a rearing mother at all ... Reproduction was a condition of her body over which she, and no one else, should have control. For some women, those developments added up to the freedom to be a surrogate.⁶⁷

Andrews' primary concern is to enable women to make decisions about their bodies and their reproductive capacities free from government restriction. She fears that a restriction on preconception arrangements would be the thin edge of the wedge that would result in the denial of existing freedoms “in the contexts of abortion, contraception, non-traditional families, and employment.”⁶⁸ Yet she fails to establish that the practice of preconception arrangements enhances the liberty and dignity of women in a way consistent with the goals of feminism.

She appears to attempt to do so by suggesting that preconception arrangements will put women in the same position as men with respect to their offspring. Andrews quotes, apparently with approval, Santa Clara University law professor Carol Sanger, who suggests that society improperly regards fathers and mothers unequally:

We don't particularly care whether men give away fatherhood before they masturbate away their heirs. Why not? In part, because the bonding has not occurred, but also because we have different expectations of fathers and their children than we do for mothers and their children.⁶⁹

Preconception arrangements enable a woman to be like a man in choosing which of her children she will rear and which she will leave to others to rear. Although the practice might, in this respect, make women like men, it is not clear that social endorsement of a practice of making such choices about offspring will enhance the dignity of either women or men. According to one critic of this position,

[I]f our expectations are that a man can masturbate into a bottle for an IVF programme, go away and not care what comes of any child who may be born as a result, or that a man can swive around as much as he likes, distributing sperm willy nilly throughout the community of women without anyone, and particularly not he, caring about the outcome of each ejaculation, is this good reason for attempting to replicate or applauding as [a] heroic, ... “feminist” or “non-moralistic” “advance” such a lack of responsibility, caring, and compassion in women?⁷⁰

Further, Andrews would require higher standards of women than of men with respect to keeping promises. She argues that once a woman

enters into the arrangement, she must be required to relinquish the child even if she does not wish to. To retain the advances of women with respect to equality with men, Andrews argues it is important that women not be allowed to claim that the process of pregnancy — a biological process — caused them to change their minds. Andrews quotes, with approval, Joan Einwohner, who interviews carrying women on behalf of Keane's Infertility Center of New York:

Women are fully capable of entering into agreements in this area and of fulfilling the obligations of a contract. Women's hormonal changes have been utilized too frequently over the centuries to enable male dominated society to make decisions for them. The Victorian era allowed women no legal rights to enter contracts ... Victorian ideas are being given renewed life in the conviction of some people that women are so overwhelmed by their feelings at the time of birth that they must be protected from themselves.⁷¹

Thus, Andrews claims that "feminists should be wary of hormone-based argument"⁷² for "we're never going to end up with a woman in the White House if we feel that raging hormones make women feel bad about their decisions."⁷³

What is curious about this argument is the notion that a woman's ability to relinquish her child under agreement should be a test of her competence in commercial and public matters. Relinquishment of children has hitherto been a matter of family law, the subjects of which are "both peculiarly important and peculiarly subject to emotions that are hard to comprehend, predict, or control."⁷⁴ Family law is sensitive to the vagaries of human desire, emotion, and vulnerability. It does not permit the fulfilment of all desires,⁷⁵ nor does it require that promises solemnly made must forever be honoured. Family law does not require a person to remain in a marriage that he or she has come to regret, because of, for example, love of another. If love of another can disrupt a voluntary agreement, why not the love of a child of one's body? Moreover, why should a woman's broken promise to strangers with respect to her child bar the doors of the White House to her and other women? More than one man has occupied it despite a history of broken promises. Further, given the disparity in socioeconomic status of commissioners and carrying women, it is odd that Andrews should argue that women's equality will be achieved by the use of less advantaged women by the more advantaged. For these reasons, the argument of liberal feminism as espoused by Andrews fails to justify the practice and the enforcement of preconception arrangements.

A third variant of the liberal argument is based on a commitment to an ideal of economic liberty and freedom to contract. Proponents of this view claim that people ought to be free to pursue their mutual economic advantage by contracting. This argument focusses not on supply but on the union of demand and supply, and therefore merits separate consideration as the fourth general argument for the practice of preconception arrangements.

The Argument of Market Efficiency

The fourth argument for the practice of preconception arrangements is that for contracts in general: they enable demand for a product or service to be met by supply in a manner that efficiently maximizes the advantages to be gained by both parties. In the context of preconception arrangements, however, this analysis is inapplicable because it assumes that costs and benefits can be expressed in monetary terms, and it takes insufficient account of "externalities," that is, harmful effects caused by the transaction to non-parties.

The argument of market efficiency is clearly articulated by Richard Posner, a judge in the Court of Appeal, Seventh Circuit, and lecturer in law at the University of Chicago. He writes,

The case for allowing people to make legally enforceable contracts of surrogate motherhood is straightforward. Such contracts would not be made unless the parties to them believed that surrogacy would be mutually beneficial ... The father and his wife must believe that they will derive a benefit from having the baby that is greater than \$10,000, or else they would not sign the contract. The surrogate must believe that she will derive a benefit from the \$10,000 (more precisely, what she will use the money for) that is greater than the cost to her of being pregnant and giving birth and then surrendering the baby.⁷⁶

Posner justifies specific performance of the arrangements on the same basis: that it permits the realization of preferences known in advance of the contract's performance. He believes that carrying women are motivated to participate in a preconception arrangement by a desire for money, and that in negotiating the agreement, the carrying woman will weigh her desire for money against the possible development of a desire to keep the child. According to Posner, the woman's weighing of these competing desires will be reflected in the price to which she agrees. To enable her to gain the best possible price, the negotiations must take place with the knowledge that, if she signs the agreement, the carrying woman will relinquish the child. Since Posner believes her goal is to gain money, he claims it is in her interest that the agreements be specifically enforceable against women who wish to keep the children. As Posner explains,

Because surrogacy is so much less attractive to the father and wife when it is not enforceable, they will not be willing to pay nearly as much as they would if it were enforceable — so the surrogate is hurt. After all, the surrogate always has the option of offering to accept a lower price in return for retaining the right to keep the baby if she wants. If she surrenders that right in exchange for a higher price, it is, at least presumptively, because she prefers the extra money to the extra freedom of choice. Her preference is thwarted if the contract is unenforceable.⁷⁷

Thus, Posner assumes that preconception arrangements can be market-efficient if they are legally permitted and if they are specifically enforceable. Under such conditions, Posner argues, total welfare will be maximized by the practice of preconception arrangements.

Posner's argument rests on at least four incorrect premises. The first is that a woman can know in advance and can assess, in monetary terms, the regret she will feel at having agreed to relinquish her child. He claims, "There is no persuasive evidence or convincing reason to believe that, on average, women who agree to become surrogate mothers underestimate the distress they will feel at having to give up the baby."⁷⁸ Yet there is such evidence. As discussed in Part 3, Nancy Reame, who counselled 41 carrying women over a period of five years, conducted research on that sample and concluded that "nearly all the surrogate mothers confessed that they had underestimated how difficult it would be to relinquish their babies."⁷⁹

Even if a carrying woman did know and could put monetary value on the cost of her future suffering, it is naive to assume that she could bargain to achieve an efficient price. There is no equality of bargaining power in preconception arrangements. Indeed if, as Posner incorrectly assumes, there were "perfect competition," carrying women would be in a superior bargaining position because demand greatly exceeds supply. But the disparity in socioeconomic status among carrying women, commissioners, and (in commercial arrangements) brokers means that from the perspective of the carrying woman, the agreement is a contract of adhesion. She has almost no power to alter its terms.⁸⁰

In addition to the incorrectness of his premises of perfect information and equality of bargaining power, Posner makes a third and more fundamental error, one that is fatal to his argument — and any argument of market efficiency. The argument assumes that costs and benefits of preconception arrangements can be quantified in monetary terms, that one can put a price on a child. But children are priceless. That they are literally without price is true for both "sellers" and "buyers" in preconception arrangements.

Consider, for example, Mary Beth Whitehead's experience. When she told the Sterns she was going to keep her baby, they responded by offering her more money.⁸¹ Of this response Whitehead wrote,

I thought their offer was very generous, but it didn't sway me one bit from wanting to keep my baby. Actually, one side of me thought it was touching, and the other side was almost insulted that they thought they could offer me more money for my child ... I didn't say anything. I just burst into tears.⁸²

That the child can be beyond price to the commissioners is also apparent in the concern often expressed by Bernard Dickens that commissioners are vulnerable to extortion.⁸³ This vulnerability exists only because the child is priceless. If the commissioned item were a custom-built chair that the furniture maker decided to retain pending payment of a higher price than that originally agreed on, then the buyer could rationally determine, despite the furniture maker's unfairness, whether the new price was acceptable. The buyer could take it or leave it. But if the

commissioned item is a child, the demand for more money is like extortion; when love of a child is involved there is almost no price a prospective parent will not pay.

That children are beyond price is exactly the reason that it is inappropriate to speak of trading them in an efficient market. Market efficiency presumes pricing, but neither sellers nor buyers in preconception arrangements can put a stable monetary value on the commissioned child. Moreover, Posner's assumption that they *ought* to do so is of questionable moral value.

A fourth and equally important criticism of Posner's argument of market efficiency is that it discounts "externalities."⁸⁴ As revealed in Part 3, there are serious actual and potential harms caused by the practice of preconception arrangements and their specific enforcement against unwilling "sellers." Yet Posner takes insufficient account of the range of persons affected and potentially affected by, and the seriousness of, these harms.⁸⁵

In sum, Posner argues that preconception arrangements ought to be permitted and enforced because they maximize the welfare of the parties who participate in them. His argument incorrectly assumes that carrying women can know in advance how they will feel about relinquishing their children and that their bargaining power is equal to that of the commissioners. More fundamentally, however, he uses the inapplicable criterion of market efficiency to evaluate the practice of preconception arrangements and takes insufficient account of externalities. It is not possible for either commissioners or carrying women to assess in monetary terms the costs and benefits to themselves of losing a child; nor does Posner adequately address the enormous potential costs of the transaction to the carrying woman and the many others affected thereby.

The Premise of Proponents' Arguments: A Market Production Model

As has been demonstrated, the four general arguments for preconception arrangements fail to justify the practice because they rely on a vision of the practice that is incomplete and misleading and they can be criticized on their own terms. Therefore, none of the arguments is convincing. There is no right to participate in a preconception arrangement any more than there is a right to the provision of a husband or wife; the practice does not address a medical need or provide medical treatment; it does not promote the freedom of carrying women by enhancing their privacy or sexual equality in dignity; and it cannot sensibly be described as market-efficient.

Although these four general arguments are each wrong in different ways, they are all wrong for the same reason. Along with the misleading depiction of the practice, the four arguments implicitly or explicitly presuppose a market for, and the production of, the good — the child — by

a seller who can and will alienate it to a buyer in exchange for valuable consideration. Thus, the proponents' arguments, and the inaccurate common depiction on which they rely, are each based on a questionable model of human procreation. That a market production model and its commodification of the child underlie the proponents' arguments can be demonstrated by examining both the nature of the transaction contemplated by proponents, and how they understand the process of pregnancy, labour, childbirth, and relinquishment.

The Assumed Social Norms of the Transaction

The four arguments for the practice of preconception arrangements assume that the desired conception occurs not in the context of mutual love, respect, and intimacy but, on the contrary, as the result of a transaction. They further assume that the transaction takes place within the context of the social norms that govern market relations.

These norms have been identified by Elizabeth Anderson,⁸⁶ who has shown that they have four⁸⁷ distinctive characteristics:

First, market relations are impersonal ones. Second, the market is understood to be a sphere in which one is free, within the limits of the law, to pursue one's personal advantage unrestrained by any consideration for the advantage of others. Third, the goods traded on the market are exclusive and rivals in consumption. Fourth, the market is purely want-regarding: from its standpoint all matters of value are simply matters of personal taste.⁸⁸

These four characteristics are each examined in turn to demonstrate that they are presumed by proponents to apply to preconception arrangements.

According to Anderson, the most characteristic feature of market relations is that they are impersonal. Each of the four arguments also assumes that this is true in a preconception arrangement: that parties view their relationship merely as a means to satisfy their ends, which are defined independently of the other party's ends. Thus, when Robertson argues that there is a right of commissioners "to contract with donors and surrogates for the gestation or gametes necessary for [the commissioners] to acquire offspring of their genes or gestation for rearing,"⁸⁹ he envisages that the parties will deal with each other on an explicitly impersonal basis of exchange in which the good that changes hands (the gametes or the child) has an equivalent value in money or other consideration that is paid in return. Similarly, the argument of medical necessity assumes that the transaction can be completed to the reciprocal advantage of each party, leaving each party free from commitments that would make them responsible to each other after the transaction is completed.⁹⁰ Likewise, the liberty arguments based on privacy and sexual equality presume that the claimed freedom "to contract with another to be paid for the performances of services, even highly personal services,"⁹¹ may be exercised in the context of impersonal market relations that define a sphere of independence from

personal ties and obligations. This freedom from future obligation toward the other party is accompanied by a correlative freedom from obligation toward the commissioned product for which the buyer accepts responsibility once he or she accepts delivery. For Andrews, this freedom from obligation toward the child is central to freedom based on sexual equality because it enables women to demonstrate that biology is not destiny.⁹² Posner explicitly views the conception of the child as being the result of impersonal relations of buyers and sellers.⁹³

The second characteristic of market relations is that participants are free to pursue their individual interests unrestrained by any consideration of other people's advantage. According to Anderson, "Each party to a market transaction is expected to take care of himself and not to depend on the other to look after his own interests."⁹⁴ This characteristic is also assumed by the proponents of the four major arguments in favour of preconception arrangements. Robertson argues that commissioners have a right to found a family by using "surrogates ... to acquire offspring of their genes or gestation for rearing." Even though this "right" would concurrently entail denying the carrying woman that same right, Robertson presumes she will take care of herself. Likewise, the OLRC's argument of medical necessity focusses on the desires of the commissioners with little regard for the health of the carrying woman (provided her health will not directly affect the commissioned child). The liberty argument similarly asserts an interest independent of that of the other parties. The privacy right of carrying women is asserted by Gostin independently of the commissioning woman's privacy right, which, arguably, entails that her husband's children be conceived within the intimacy of their relationship. The liberty to give birth but not to rear one's children is asserted by Andrews also without regard to the consequences for the commissioning woman's sexual equality in her marriage. If she must give up her job to raise her husband's child by another woman, then the argument presumes it must be because she wanted to do so. The transaction is assumed to satisfy all the parties, who seek their own interests and no one else's. According to Posner, this is true by definition.

The third characteristic of the social norms governing the market relations identified by Anderson is that the parties' interests can be defined only with respect to goods that are exclusive and are rivals in consumption. Anderson defines an "exclusive good" as one where access to its benefits can be limited to the purchaser. A good is a rival in consumption if the portion that one person consumes reduces the total amount of it available to others. The four arguments assume these characteristics of commissioned children in positing that they might be surrendered by carrying women into the exclusive custody of the commissioners. The arguments assume that the child is "exclusive" insofar as they do not advocate that custody be shared. They also assume that the child is a rival in consumption insofar as its years of childhood and early adulthood, when

enjoyed exclusively by the commissioners, cannot later be retrieved to be enjoyed by the carrying woman.⁹⁵

The fourth characteristic of the market identified by Anderson is that it responds to "effective demand," that is, desires backed by the ability to pay. In a market, commodities are exchanged without regard to the reasons people have for wanting them. This means that the market responds not to needs *per se* but to the ability to pay, and that it draws no distinction between needs and desires. The purely want-regarding nature of demand is presupposed by Robertson, who claims that the "right to procreative liberty" entails, among other things, the right of persons to have a child for the reason that they have "needs or desires to have and rear biological descendants."⁹⁶ Similarly, the OLRC and the AFS collapse the distinction between need and desire with their claim that the desire (albeit an intense desire) for a genetically related child is a medical need. (That they do not clearly distinguish between desire and need is obvious from the fact that they would view as legitimate the "need" of a man for a genetically related child where his wife is simply too ill to be pregnant. In such circumstances, where the ill woman is expected to rear the child, the agreement might satisfy his wants but certainly not her medical needs.) Likewise, Andrews claims that commissioning women who delayed childbearing *need* to turn to preconception arrangements. Posner does not rely on a false notion of "need" but believes that the very fact that the arrangements satisfy wants is sufficient justification.

A second consequence of the fact that market relations are purely want-regarding is that effective demand is satisfied irrespective of the reasons purchasers might give for wanting the good. "The market provides individual freedom from the value judgments of others. It does not regard any one individual's preferences as less worthy of satisfaction than anyone else's, as long as one can pay for one's own satisfaction."⁹⁷ This is how Robertson can justify the demand of a single man to commission a child,⁹⁸ and the OLRC and AFS can justify the same demand of a man married to a seriously ill woman. The point is not to argue that these demands ought not to be satisfied, but rather to make evident that these two demand-based arguments (from rights and medical need) derive the legitimacy of demand almost exclusively from the existence of effective demand itself. Such arguments do not attend to other considerations such as, for example, the best interests of the commissioned child. Similarly, the liberal argument also assumes that effective demand be satisfied when it presupposes, whether for reasons of privacy or sexual equality, that a woman's desire to conceive a child for surrender ought to be accommodated. Posner explicitly adopts a market view that effective demand ought to be permitted to be met by supply in that, as was discussed, he takes no account of externalities.

The Assumed Process of Production

In addition to assuming the existence of market relations, proponents of the four general arguments in favour of preconception arrangements make a second significant assumption: they presume that the process by which the commissioned child comes into the world is a process of production. Their arguments are most coherent on the theory that the process by which the subject of the preconception arrangement becomes a child takes place inside a black box: hidden from public view, the process carries on until production is complete and the product exits from the box — which itself is not significantly affected by the production process or the exit. Until the exit, there is no product; after the exit, the process and the box are irrelevant. The product, though produced in the box, has no memory of it and is readily capable of being transferred into the exclusive possession of those who ordered it.

This black box theory of production makes sense of the proponents' arguments. Robertson, for example, acknowledges that "moral sensibility recoils at transforming the mystery of birth into a commercial transaction."⁹⁹ But he suggests that the transaction is better viewed in other terms: as initiating the process that fulfils a "desire to procreate or to assist others to do so [which is] more important than the need to maintain this symbol of maternal-child bond."¹⁰⁰ Here, Robertson implies that the relationship between mother and child, symbolized by the term "bond," is like a trade logo that, when affixed to the black box, should be removed if it gets in the way of the transfer after exit.

The OLRC and the AFS similarly adhere to a black box model of the process that is initiated by a preconception arrangement. The OLRC contemplates either that the carrying woman will be unaffected by the process or that she will bond with the child *after birth*.¹⁰¹ Its report states that "knowledge about the degree of bonding of the infant in the womb" is "particularly speculative."¹⁰² Apparently, the OLRC does not consider that the child might have developed a relationship with the carrying woman in the sense that it knows her voice and heartbeat, and the voices of other people in her household. From its black box premise, the OLRC would require proof that the product might form a relationship with the producer during production before it will be "persuaded that prohibition is warranted."¹⁰³ The AFS, on the other hand, contemplates that both the carrying woman and the commissioned child might be negatively affected by the process and the separation, but it does not see that unproven possibility as sufficient to override the "need" for the fulfilment of demand for preconception arrangements.¹⁰⁴

The liberty arguments of privacy and sexual equality are, in this respect, unlike the rights and medical need arguments that focus on demand; in concentrating on supply, the liberty arguments assume the significance of the process for the carrying women. The privacy argument as espoused by Gostin is unique among the proponents' arguments considered here in acknowledging that pregnancy and childbirth can create

an intimate relationship between mother and child, and in stating that the relationship ought not to be interfered with unless the woman so wishes. Gostin's view, however, focusses on the interests of the producer, not the product, and therefore states that "surrogacy arrangements do not pose any clear harm to children," by which he means only commissioned children and not the other children affected by the arrangement.¹⁰⁵ Andrews' liberty argument, unlike Gostin's, would require the carrying woman to deny any desire she might feel to retain the child in order to preserve her capacity to contract in other commercial and production contexts.¹⁰⁶ For Andrews, the product itself is transferable from seller to buyer.

Posner's view that the process of pregnancy and birth takes place in a black box is obvious when he criticizes the New Jersey Supreme Court for holding that the "whole purpose and effect of the surrogacy contract was to give the father the exclusive right to the child by destroying the rights of the mother."¹⁰⁷ Posner responds by claiming that

the court neglects an obvious point: no contract, no child. It's not as if there was a baby and the mother was being asked to give up her rights in it. There was no baby when the contract was signed; the "whole purpose" of the contract was not to destroy the mother's rights, but to induce a woman to become a mother.¹⁰⁸

Clearly Posner sees the process of procreation like any other sort of commissioned labour. When one orders a pizza in a restaurant and puts money down, one ought not to be later accused of taking food from the mouth of the cook. There was no pizza when the patron ordered it. The whole purpose of the contract was not to starve the cook but to induce him or her to cook a meal for the patron. Not only does Posner thus adopt a black box theory of procreation, but he assumes that the child is like a product. That Posner adopts a product model of the child is why he cannot understand the New Jersey Supreme Court's statement that the practice of preconception arrangements "totally ignores the child."¹⁰⁹ Posner replies, "On the contrary, surrogacy is a method of encouraging the conception of the child."¹¹⁰ Posner consistently considers procreation to be production. What Posner does not seem to understand is that in the process of procreation, a mother develops a relationship with her child that is unlike the relationship of a cook to pizza, and that a child has interests of its own, which the practice totally ignores by contemplating the child's conception for removal from its mother and her family.

The Market Production Model as a Basis for Legislative Reform

Thus, it has been demonstrated that the four general arguments of proponents of preconception arrangements implicitly or explicitly assume the existence of market relations among the parties and a black box theory of reproduction; they adopt a market production model of the practice that brings commissioned children into the world. This model assumes that the genetic and gestational parents of a child will, at the time of the child's

conception, have an impersonal relationship with each other, that each should be entitled to pursue his or her own advantage to the fullest extent legally permitted, that custody of the child will not be shared, and that commissioners' entitlement to become parents should be circumscribed only with respect to their ability to pay to have their desires realized.¹¹¹ The market production model also presumes that neither the supplier (the birth mother) nor the product (the child) is likely to be sufficiently hurt by the arrangement to justify removing such arrangements from the range of opportunities provided by the market. We have seen that this model does not take into account the harms and potential harms to the carrying woman's family and to the commissioning woman. Nor does it take into account the harm done, by commodifying women's reproductive capacities and children in this way, to our view of women and children generally.

Nevertheless, on the basis of the market production model, proponents of the practice of preconception arrangements view current law in Canada and in the United States as insufficiently accommodating of the desires of commissioners and carrying women to enter into, and to effect, a preconception arrangement.¹¹² Therefore, they seek law reform that would facilitate entry into the arrangements, resolve uncertainty about parentage and custody in advance of the child's birth,¹¹³ and, in some cases, require the carrying woman to relinquish the child to the mother.¹¹⁴ Such proposals for law reform are grounded in the view that, in general, contract law is the best legal means to govern preconception arrangements. For, like the market production model itself, contract law presupposes that there is value in parties uniting to agree on the production and transfer of a good in a manner that is likely to realize the interests of the parties to the agreement. Contract law, like the market production model, relies on the social norms of market relations and a black box theory of production. Proponents of preconception arrangements would use these presuppositions of contract law to regulate the practice and to give legal effect to intentions expressed prior to conception.

Consider, for example,¹¹⁵ the proposal of the American Bar Association Family Law Section entitled "Draft ABA Model Surrogacy Act" [hereinafter the ABA Proposal].¹¹⁶ It explicitly aims, *inter alia*, "to facilitate private reproductive choices by effectuating [sic] the parties' intentions while minimizing the risks to the parties."¹¹⁷ The purpose of the ABA Proposal is to give effect to the agreement between the parties for the production and transfer of the commissioned child. The proposal would govern the relations among the parties in accordance with the social norms of market relations, as identified by Anderson, and assumes a black box model of procreation.

In the first instance, the ABA Proposal assumes that the parties have impersonal relations; the proposal contemplates that they may not know each other and that they may not wish to come to know each other as they create a child. Section 5(o) provides that the contract must state whether the parties intend to meet, and takes into account that, for example, the

commissioners might know the identity and residence of the carrying woman but that she will not know them: "There need be no mutuality with respect to the knowledge of one party's name."¹¹⁸ By keeping secret the commissioners' identity, such a provision would prevent a carrying woman from attempting to continue her relationship with the child that she was hired to produce. The proposal thus contemplates an impersonal relationship between the parents of the commissioned child.

Secondly, the ABA Proposal would permit the parties each to pursue his or her own advantage to the greatest extent permitted by law. The parties would be entitled to sue on their agreement to obtain both money damages for breach of a term¹¹⁹ and specific performance of the promises to relinquish and to accept the child.¹²⁰ Because a woman has a constitutional right in the United States to have an abortion, the proposal acknowledges that the commissioners cannot prohibit her from exercising that right, but they would be entitled to sue her for money damages should she do so.¹²¹ If the woman delivers a child but refuses to relinquish it, the commissioners may hire a private detective to locate her and the baby, and then bring her to court to force her to give them the child. If they are successful in the action, the commissioners will be entitled to an award of costs against the carrying woman, both for legal fees and for the private detective.¹²² Thus, the proposal enables people whom the carrying woman might never have met to sue her for exercising her constitutional right to abortion. If she does give birth, the proposal would enable them to track her down and take her to court to force her to give them the baby, which doubtless she would be nursing. In addition, despite the probability that she will have much less money than they, the commissioners would be entitled to extract from her payment for their lawyer and the private detective they hired.

The ABA Proposal also assumes the third of Anderson's characteristics of market relations: that the commissioned good will be exclusive and rival in consumption. The carrying woman will have neither custody nor access. Indeed, she will cease to be legally related to the child after a hearing to give effect to the agreement by judicial order that "the intended parent or parents shall retain or assume custody and full legal responsibility for the child."¹²³ This transfer of legal responsibility, though in effect an adoption, is to be ordered not on the basis of the best interests of the child (of which no inquiry is made) but rather on the basis of whether the parties knowingly and voluntarily entered the agreement, whether it conforms to the requirements of the statute, and whether all requisite petitions have been filed.¹²⁴

Fourthly, the ABA Proposal assumes that a man may commission a child almost exclusively according to whether he can pay. The only inquiry made of the commissioner is an examination by a social worker to determine whether the intended parent or parents "appear to be suited to going through the process of having a child through surrogacy and raising a child born of a surrogacy agreement."¹²⁵ The proposed statute provides

no criteria for making such a determination. Doubtless, in practice one criterion would be whether the commissioner could afford the costs.¹²⁶

In addition to assuming that the parties' relations will be governed by the market's social norms, the ABA Proposal views the process of conception, pregnancy, labour, delivery, and relinquishment as occurring within and from a black box. The mother is the producing machine and the baby, the product. Of principal concern in the proposed statute is not whether the process will damage the mother but rather whether she will give up the child. For this reason, the statute requires her to be examined by a medical doctor, a mental health practitioner, and a social worker.¹²⁷ The mental health practitioner must determine whether, *inter alia*, the prospective carrying woman "is mentally and emotionally capable of entering into a surrogacy agreement."¹²⁸ It is not clear by what criteria a psychiatrist or psychologist could determine this. Similarly, the social worker must "state whether the prospective surrogate appears to be suited to being a surrogate."¹²⁹ But again, the criteria are not given to determine whether a woman is suited to becoming pregnant by a stranger, experiencing a pregnancy, going through labour and delivery, and then giving up her child.

That the concern of the statute is for the woman not *qua* human being but *qua* producer is evident from the requirement that the commissioners insure her life during the course of the insemination, pregnancy, and birth. In an interesting section, the proposal would relax the requirement that commissioners obtain an insurance policy "with minimum death benefits of \$100 000" where the prospective carrying woman is in poor health:

If the condition of health of the surrogate makes the premiums for such a policy extraordinarily expensive, the amount of death benefits may be reduced so that the premium would be approximately what would be paid for \$100 000 of death benefits for a healthy person of the same age as the surrogate.¹³⁰

Thus, the proposed statute considers the financial cost to the commissioners of hiring an inferior producer but not the social and psychological cost to a woman in poor health and to her family should her health be seriously compromised or should she die in an attempt to produce "the parents' child."

That the child is perceived as a product under the proposed statute is apparent in the section that states that the commissioner or commissioners need not accept a child if, even though it is in good health, it is not what they contracted for:

If the intended parent or parents prove that the child is not as intended, that is, not genetically related to the providers of genetic materials, then the intended parent or parents shall not be required to retain or assume custody and shall be required to make all payments pursuant to the terms of the agreement.¹³¹

Despite the proposal's claim that it aims "to facilitate the creation of a parent/child bond,"¹³² it would permit the commissioning man to send the child back if tests revealed that his sperm did not participate in the child's conception. Moreover, the commissioner could then sue the carrying woman for money damages for conceiving a child by her own husband rather than by him.¹³³

Thus, on the assumption of market relations and black box production, and the resulting view that preconception arrangements must be governed by the norms of contract law, the ABA Proposal would enable strangers to a woman to sue her for having an abortion or having a child with her husband and, if she gives birth to a child conceived with the commissioner's sperm, to take her baby forcibly from her. Moreover, even though the proposed statute contemplates that the carrying woman will already have children,¹³⁴ it would take no account of the effect on them of this forced removal of their half-sibling, or on the other members of the carrying woman's family, her partner, and her parents. Despite all of these consequences, a preconception arrangement that conformed to the proposed statute would be "valid as a matter of public policy."¹³⁵

How is it possible that these activities could ever be thought justifiable as a matter of public policy? The answer is that one need only assume that preconception arrangements exist within the framework provided by the incomplete and misleading picture, that the relations among the parties ought to be governed by the social norms of the market, that a preconception arrangement is about production not procreation, and that therefore contract law ought to govern. One can arrive at such a proposal for legislative reform only on the basis of this seriously deficient model of procreation. To quote Kenneth Boulding,

We cannot walk before we toddle,
But we may toddle much too long
if we embrace a lovely Model
that's consistent, clear and wrong.¹³⁶

Part 5. Legislative Proposal

An Alternative Basis for Legislative Policy: A Growth Perspective

The practice of preconception arrangements has been demonstrated to have actual and potential effects that are harmful to a wide range of persons affected by the practice. The arguments advanced by proponents of the practice discount these effects because they consider procreation under a preconception arrangement to be market production. Reliance upon this false model of procreation also encourages proponents to advocate a legislative policy that would use contract law to govern the practice. But the use of contract law with its norms of market relations

and specifically enforceable promises would, as the ABA Proposal makes clear, give rise to the harmful effects that legislative policy should aim to prevent.

For these reasons, the market production model of procreation must be rejected in favour of an approach that recognizes that the process of conception, pregnancy, labour, and childbirth occurs not in a black box but in a woman's body and within the context of a growing relationship between her and her child. Such a legislative perspective would acknowledge that a child is not manufactured but brought to birth; that a child is not produced but procreated. It would express not the attitude of the confident in observing the predicted, but that of the humbled in witness of the miraculous. An adequate approach to legislative policy would recognize that there are limits to human ability to control procreation. Such an approach might be called a "developmental approach" or a "growth perspective."

According to Ursula Franklin, growth is significantly different from production:

Growth occurs; it is not made. Within a growth model, all that human intervention can do is to discover the best conditions for growth and then try to meet them. In any given environment, the growing organism develops at its own rate ... [Whereas] production is predictable ... growth is not. There is something comforting in a production model — everything seems in hand, nothing is left to chance — while growth is always chancy.¹

A growth perspective on procreation recognizes that procreation is not predictable. Thus, it explains how, in the context of pregnancy and childbirth, prior intentions are of little significance in predicting outcomes. For example, consider the remarks of the commissioners' lawyer in the *Baby M* case. Gary Skoloff claimed that the term "surrogate mother" is inaccurate because it wrongly implies that the carrying woman is a mother:

It may be that the term "surrogate mothering" is a really improper term, because you hear the term "mother," which means [that she] is going to nurture and raise a child. That's exactly what nobody intended in any kind of an agreement involving surrogate parenting.²

But whether or not anyone intended it, the preconception arrangement caused Mary Beth Whitehead to conceive and nurture a child within her body and that experience created in her an overwhelming desire to rear the child that, in a profound sense, thus had become hers. Skoloff assumes maternal feelings can be planned to exist or not because he thinks of what Whitehead did as production. Obviously it was procreation; she grew physically and psychologically to accommodate the growing child. Such growth simply occurs and makes a mockery of planning and intentions. As Katha Pollitt has written,

Planning to have a baby is not the same as being pregnant and giving birth ... The long months of pregnancy and the intense struggle of

childbirth are part of forming a relationship with the child-to-be, part of the social and emotional task of parenthood.³

Pollitt goes on to state that a woman's feelings, whatever her intentions, are likely to change and that this change is not to be discouraged:

[I]s there a woman who feels exactly the same about the baby in the ninth month, or during delivery or immediately after, as she did when she threw away her diaphragm? ... Whether or not there is a purely biological maternal instinct, more mothers, and more fathers, fall in love with their babies than ever thought they would. Indeed, if they did not, most babies would die of neglect in their cribs.⁴

The growth of a mother's and father's feelings for their child is necessary for the further growth of the child. These feelings, however, cannot meaningfully be discussed in terms of being "intended" or "planned." A growth perspective respects such feelings, indeed welcomes them, acknowledging that humanity has relied upon them for its very existence.

A growth perspective, unlike the market production model, is a sound approach to legislative policy because it accurately envisions the process by which a child is gestated and delivered as one that has the power fundamentally to alter the way a woman views the child, and, equally significantly, to create a being who is extremely needy and extraordinarily vulnerable. Acknowledging the potential and probable desire of the mother to attend to the neediness and vulnerability of her child, and the fact that her lactating body and the familiarity of her voice and heartbeat make her, from the perspective of the child, uniquely well suited to do so, a developmental approach would encourage legislative policy that allows women to be free from economic and psychological inducements to part with their children. In being rooted in a respect for life, a growth perspective prompts legislative policy that would treat children as persons, not as things capable of being created and exchanged for money. Further, it would recognize the vulnerability of both carrying women and commissioners that encourages them to believe in brokers' assurances and in their own hopes that carrying women, by relinquishing children of their bodies, are likely to gain more than they will lose. In the face of this desperation, suffering, and compassion, and in view of the unpredictability of human emotion, a growth perspective wisely would strive not to maximize gain (as the market production model attempts in vain) but merely and importantly to minimize disaster.⁵

Whereas the market production model (so inadequate here as a basis for legislation) finds expression in contract law, a growth perspective is evident in a different species of private ordering; like contract law, it gives effect to intentions solemnly expressed, but unlike contract law, it nevertheless will set them aside because of unpredicted emotional growth. That body of law, family law, attempts to minimize disaster when humans grow apart; it counts among its purposes the goals of protecting children's welfare and interests, promoting human well-being, and preventing human

exploitation.⁶ Family law is based on a growth perspective's understanding of the centrality to human personhood of relationships and their essential mutability. Therefore, family law is a body of law much better suited than contract law to govern preconception arrangements.

Family Law as the Means of Governance

We return, therefore, to family law.⁷ As we saw in Part 2, the criteria that family law would use to govern preconception arrangements are radically different from, and more appropriate than, the criteria offered by contract law. Whereas contract law would seek to give effect to adult intentions, family law would aim to promote the best interests of the child. Whereas contract law might presume that the commissioned item is a product that has no interests of its own and to which the producer has neither entitlement nor attachment, family law views children as vulnerable human beings to whom mothers and fathers owe serious obligations.

As has been demonstrated in Part 2, family law in Ontario has already considered the central aspects of preconception arrangements, albeit not in the specific context of such an agreement.⁸ Family law would likely render unenforceable or illegal each of the four central provisions of a preconception arrangement, *viz.*: custody transfer, relinquishment of maternal rights, payment for adoption, and unsupervised placement of child for adoption. Ontario family law would not give effect to these central provisions of a preconception arrangement because it is based on a developmental approach to procreation. This can be demonstrated by examining each of the central provisions in turn.

The promise to transfer custody from the mother to the father would be void except insofar as the transfer served the best interests of the child.⁹ It is unlikely that a preconception arrangement could satisfy that test because, at the time the arrangement is made, the child's interests are not known, and because the agreement itself demonstrates that the adult parties seek to promote their own interests and only incidentally those of the child. The reasoning that underlies this best interests requirement accords with a growth perspective. It is based on the recognition that one cannot predict one's own or another's feelings, the growth of a child, and how future growth might best be guided.

The second central provision of a preconception arrangement would also probably be invalidated by Ontario family law in a manner that comports with a growth perspective. The second provision purports to be the irrevocable surrender of maternal rights to the child, in advance of the child's conception. In Ontario, no parent may consent to the adoption of her or his child until the child is at least seven days old, and the parent may revoke that consent within 21 days of having given it.¹⁰ As was suggested in Part 2,¹¹ these statutory provisions aim to enhance a birth mother's freedom to make important decisions. Consistent with a developmental approach, the statutory provisions assume that a woman

cannot know how she will feel about relinquishing the child until after its birth, and that because giving birth is an exhausting and emotional process, she ought to have at least one week to recover before any decision to relinquish has legal force. Because an adoption order is final and a birth mother has no standing in the adoption process once her consent has been validly given,¹² she is permitted a grace period in which to change her mind. This statutory regime enhances a woman's freedom by fostering the conditions in which she might appraise the growth of her relationship to her child and take a decision as to what is best for her child and herself.

The third central provision in a preconception arrangement is also probably invalid for reasons that are consistent with a growth perspective on procreation. In paid arrangements, the commissioning man agrees to pay the carrying woman a substantial sum (usually about U.S. \$10 000) when her maternal rights are terminated and provided he has custody of the child.¹³ However, it is illegal in Ontario to pay or to receive payment in connection with a child's adoption or with giving consent to adoption.¹⁴ The purpose of this statutory provision apparently is to protect parents from receiving financial inducement to part with their children, and to prevent the consequent sale of a child as a commodity without regard to its interests. In so doing, this rule recognizes that parents and children are vulnerable to exploitation, and that children are not products and ought not to be sold.

Not only does Ontario family law make illegal the payment or acceptance of payment in exchange for consent to adoption, and render void any unpaid consent to adoption given before birth, it makes illegal the activity of commercial brokers. It will be recalled that brokers charge a "finder's fee" of up to \$11 000 (U.S.) to the commissioners for procuring prospective carrying women.¹⁵ Under Sec. 159(c) of the CDSA, it is illegal for a person to receive such payment for "negotiations or arrangements with a view to the child's adoption." By Sec. 160(4), a person who accepts or receives payment and a director, officer, or employee of a corporation who authorizes, permits, or concurs in the acceptance of payment are guilty of an offence punishable by a fine of not more than \$25 000, or imprisonment for a term of not more than three years, or both. These provisions are likewise consistent with the view that parents can be exploited, that children are not products, and that no one should be permitted to capitalize upon their vulnerability.

The final central provision of a preconception arrangement concerns the adoption of the child by the commissioners without state supervision.¹⁶ Just as a growth perspective acknowledges that harm can come to a child who is taken from its mother or raised by a person not its parent, Ontario law requires that an adoption (whether "stranger" or step-parent) be approved by court order.¹⁷ Whereas the preconception agreement seeks to achieve an adoption because it is in the interests of the adults, the court may grant an adoption order only because to do so would be in the best interests of the child.

Thus, Ontario family law rejects a market production model of procreation and recognizes that (1) a child is a vulnerable human being, not a product; (2) its best interests ought to govern any transfer of the child's custody; (3) a birth mother ought to be given time after gestation, labour, and delivery to make a decision about what is in the best interests of her child and herself; (4) a mother ought not to be placed in the position of being offered money for her child; (5) no one ought to profit from the commodification of children; and (6) every adoption order must be granted only on the basis of the child's best interests. Ontario family law is based on a growth perspective, which holds that children are of value in themselves and ought not to be valued in accordance with how much another is willing to pay for them. It acknowledges the powerful effect of pregnancy and childbirth on the way women can come to view even an unwanted pregnancy by giving the mother time after birth to decide what to do and then to revoke that decision. Moreover, it is sensitive to a woman's vulnerability when she is pregnant and immediately afterward, and therefore prohibits brokers from acting in profit-seeking ways that are likely to capitalize on that vulnerability rather than to reduce it.

Legislative Policy Based on a Growth Perspective and Family Law

Having demonstrated the appropriateness of a developmental approach to procreation and that family law has adopted such an approach and is therefore an appropriate means of governance, we are now in a position to consider what legislative policy would best address the practice. If the purpose of legislation is to eliminate or diminish the actual and potential harms of preconception arrangements, how ought we to legislate? This question has been helpfully considered by the New York State Task Force on Life and the Law,¹⁸ which thereby developed a legislative policy worthy of endorsement in Canada.

The Task Force proceeded from the assumption that society has an interest "in protecting and promoting those social values and institutions it deems primary to its collective life."¹⁹ The practice of preconception arrangements affects that interest because it

touches upon basic values and relationships in our private and collective lives: the interests of the children, the role of the family, attitudes about women, and the potential commercialization of human reproduction.²⁰

Because it considered that society ought to protect the best interests of children, and ought to shield gestation and reproduction from the flow of commerce, and that this obligation is evident in the large body of statutory law on custody and adoption, the Task Force determined that the state ought to act. To do nothing in response to the practice would leave these central goals "vulnerable to the dictates of the market place,"²¹ which would be contrary to the public interest.

For these reasons, the Task Force reached a unanimous decision that public policy should discourage the practice of preconception arrange-

ments. It believed that the payment of fees and the existence of a contractual obligation to relinquish the child at birth constitute baby-selling, place children at risk, and are not in their best interests. The fact that the practice condones the sale of children would, in the Task Force's opinion, have severe long-term implications for how society thinks about and values children. More immediately, it puts children at risk by deliberately causing them to be born into situations where their genetic, gestational, and social relationships to their parents are irrevocably fractured. The Task Force would not accept the argument of proponents that these harms could be outweighed by the opportunity for life itself. That argument assumes the very factor under deliberation — the child's conception and birth. "The assessment for public policy occurs prior to conception when the surrogate arrangements are made. The issue then is not whether a particular child should be denied life, but whether children should be conceived in circumstances that would put them at risk."²²

In addition to being contrary to the interests of the children, the practice was considered by the Task Force as having the potential to undermine the dignity of women, children, and human reproduction. To imagine that the gestation of children is a service for others in exchange for a fee is a radical departure from the way society understands and values pregnancy. This radical, new view of human reproduction uses a market production model rather than a developmental approach to procreation, for it

substitutes commercial values for the web of social, affective and moral meanings associated with human reproduction and gestation ... It treats women's ability to carry children like any other service in the marketplace — available at a market rate, based on negotiation between the parties about issues such as price, prenatal care, medical testing, the decision to abort, and the circumstances of delivery. All those decisions and the right to control them as well as the process of gestation itself are given a price tag — not just for women who serve as surrogates, but for all women.²³

The Task Force concluded that these market relationships and assignment of market values should be rejected as a derogation from the true values and meanings associated with human reproduction that derive from the intimate relationship between the mother and the father, and are linked to the love and commitment a woman feels for the child she will bring into the world. Although the commissioners might be a couple who are frustrated in their attempt to deepen their relationship by begetting a child, they use a woman as a vehicle to serve their own ends; they

seek the biological components of gestation from [the carrying woman] while denying the personal, emotional and psychological dimensions of her experiences and self. If she succeeds in denying her emotional responses during this profound experience, she is dehumanized in the process. If she fails, her attachment to the child produces a conflict that cannot be resolved without anguish for all involved.²⁴

Further, the Task Force viewed a preconception arrangement as immorally designed to make the obligations that accompany parenthood alienable and negotiable.

The Task Force therefore advocated legislation that would declare preconception arrangements void and would ban both paid and commercial arrangements. It stated that existing laws on adoption and artificial insemination would permit the arrangement where it is unpaid and non-commercial, and where the arrangement remains undisputed. Where preconception arrangements result in disputes about custody, the Task Force recommended that custody should remain with the birth mother (irrespective of the origin of the ovum) and her husband, if any, unless and until the court finds, "based on clear and convincing evidence, that the child's best interests would be served by awarding custody to the father and/or the genetic mother."²⁵ In the Task Force's opinion, this proposal would greatly reduce, though not entirely eliminate, the practice of preconception arrangements and its attendant harms.

Because the New York State Task Force's policy emphatically rejects the market production model and proceeds from a more complete and accurate view of the practice and a growth perspective on procreation, it is a judicious precedent for legislative policy in Canada.

A Legislative Proposal

Introduction

Having affirmed the appropriateness of family law as a means of governance and having endorsed the New York State Task Force's policy of active discouragement, we now make a proposal for legislation. The proposal is simple and conventional in advocating that existing family law in Canada's provinces and territories should be specifically applied to preconception arrangements in legislation that would address the 10 central legal questions to which the practice gives rise:

1. May preconception arrangements be enforced at law?
2. May a woman consent to relinquish her rights to, and responsibilities for, a child before conception or birth?
3. May persons offer, give, or receive money in connection with the relinquishment of parental rights and responsibilities?
4. May persons act as, or hire, a broker?
5. May persons advertise for, or advertise their willingness to act as, a broker or a carrying woman?
6. How shall legal maternity be determined?
7. How shall legal paternity be determined?
8. How should custody be determined in the event of a dispute concerning a commissioned child?

9. May the non-custodial parent have access to the child?
10. May the non-custodial parent be required to pay maintenance for the child?

Taken together, the answers to these questions constitute a proposal for legislation specifically to address preconception arrangements. In drawing upon family law in Ontario, the proposal is suitable for that province, and can serve as an example of how other provinces and territories might similarly rely on their existing body of family law as a source of legislation to govern the practice in their respective jurisdictions.²⁶ To the extent that Ontario family law has not addressed one of the issues to which preconception arrangements give rise, this proposal relies upon a developmental approach to procreation inherent in family law²⁷ and the proposed legislative policy of discouraging the practice.²⁸

Recommendations

1. May preconception arrangements be enforced at law?

Legislation should be enacted that specifically declares that preconception arrangements are void and of no legal effect.

As evidenced by the Ontario FLA,²⁹ the Ontario CLRA,³⁰ and the Canada Divorce Act,³¹ the test of the validity of an agreement regarding the custody of children is the best interests of the child. Part 2³² demonstrated that a preconception agreement cannot satisfy this test because the child (by definition) is not even conceived at the time the agreement is made and therefore its interests are not knowable. A second reason that a preconception agreement cannot meet the best interests test is that the agreement aims to promote the interests of the adult parties and only incidentally those of the child. For these reasons, legislation ought clearly to state that preconception agreements are a legal nullity and are therefore unenforceable at law.

2. May a woman consent to relinquish her rights to, and responsibilities for, a child before conception or birth?

The statutory rules that dictate when a woman may validly relinquish her maternal rights and responsibilities so that her child may be adopted should be made specifically applicable to all mothers, including those who have signed preconception agreements or who have otherwise entered into a preconception arrangement. Ontario family law states clearly that no parent may consent to the surrender for adoption of his or her child until the child is seven days old,³³ and grants consenting parents the right to withdraw their consent within 21 days thereafter.³⁴ By making these provisions specifically applicable to preconception arrangements, the proposed legislation would affirm that any putative consent to relinquish parental rights and duties prior to conception is void.

3. May persons offer, give, or receive money in connection with the relinquishment of parental rights and responsibilities?

Legislation ought to declare it illegal to offer, give, or receive money in connection with the relinquishment of parental rights and responsibilities toward a child commissioned by a preconception arrangement. In so doing, the legislation would merely make it clear that the statutory prohibition against payment for the relinquishment of parental rights in adoption³⁵ applies also to prevent this practice.

The penalty for violating this provision would be a fine to a maximum of \$25 000, imprisonment of up to three years, or both. This penalty already exists in Ontario family law and aims to prevent persons from offering or giving financial inducements to parents to part with their children, and to prevent parents from accepting such payment.³⁶

4. May persons act as, or hire, a broker?

It should specifically be declared illegal to act as, or to hire, a preconception arrangement broker, and to offer, give, or receive payment for a broker's services. This recommendation would make apparent that it is an offence for anyone who is not a government-approved children's aid society or a licensee to place a child for adoption,³⁷ and that it is illegal to agree to receive or to receive payment or reward of any kind in connection with "negotiations or arrangements with a view to the child's adoption."³⁸

It is proposed that the penalty for violating these provisions ought to be a fine of not more than \$25 000, imprisonment for a term of not more than three years, or both. This penalty is provided by Sec. 160(4) of the CFSA.³⁹

5. May persons advertise for, or advertise their willingness to act as, a broker or a carrying woman?

Legislation should declare it illegal to advertise for, or of one's willingness to act as, a broker or a carrying woman, and to publish such an advertisement. Although Ontario family law does not appear to have a direct precedent for a ban on advertising in matters related to adoption, such a ban is consistent with rejecting a market production model of procreation and with the legislative policy of discouraging the practice of preconception arrangements. Moreover, as shall be discussed in Part 6, there is precedent for prohibiting advertising regarding preconception arrangements in other common law jurisdictions that have passed legislation concerning the practice.⁴⁰

It is proposed that the penalty for advertising or for publishing an advertisement regarding a preconception arrangement be a fine of not more than \$2 000, imprisonment for a term of not more than two years, or both. This is the penalty provided by Sec. 160(1) of the CFSA for unlawful attempts to circumvent the statutory adoption scheme by making unauthorized placements.⁴¹ Arguably, advertising is another form of circumventing the statutory adoption scheme and therefore ought to attract the same penalty.

6. How shall legal maternity be determined?

Legislation ought specifically to declare that the mother of a child is the person who has given birth to the child, irrespective of the origin of the ovum. This recommendation is consistent with the principles that there be no market in women's reproductive capacities and that the best interests of the child be of paramount concern.

When a carrying woman conceives within her own body (whether by sexual intercourse or artificial insemination) the question of maternity is not at issue. She is the child's mother in every sense. Yet when a carrying woman gestates an embryo derived from another woman's ovum, how should maternity be determined? The only case to have considered the matter⁴² decided that maternity should be determined by testing for genetic relatedness. This rule is not, however, in the interests of women or children.⁴³

The better rule, which states that the woman who gives birth is the mother, would prevent the exploitation of poor women in Canada and elsewhere, and the development of the notion that women are merely vessels or incubators of fetuses, to be treated as such. The rule has the advantages also of relying for its application on the unaided senses rather than costly laboratory work, and of being incapable of error. Further, the rule ensures that there is no period during which maternity is undetermined. This has important repercussions for all women. The alternative would mean that every pregnant woman would be open to a charge of kidnapping (pending genetic identification of the fetus) when she crossed a border and that her experience of childbirth would be altered as personnel prevented her from taking the newly delivered child in her arms whilst they awaited laboratory test results.

The rule that legal maternity is determined by giving birth is also in the interests of children. Because embryos can now be frozen and transported by aircraft, it is possible that an ovum provider might be on another continent when the resulting child is born. Thus, it is not in a child's interests for legislation to declare that the woman who has gestated, laboured, and given birth and is ready to continue to nourish the child is a stranger to the child, in favour of a woman who, though the genetic parent, is not otherwise connected to the child. The proposed rule would ensure that at least the female adult who is responsible for the child is known at the time of the child's birth and is present as the child enters the world.

Whilst acknowledging that a commissioning woman might suffer terribly from not being recognized as the legal mother despite her longing for a(nother) child, the pain she endured by having her egg(s) extracted, and the fact that the child might look just like her, this proposal's purpose is not to increase her suffering. It recognizes the even greater contribution of the gestational mother, the growth of relationship between the gestational mother and child, and that the technology that separates genetic and gestational motherhood is itself the cause of much of the resulting harm.⁴⁴

This proposal aims to discourage the practice by preventing the further suffering and exploitation of women, and by favouring the interests of children rather than the interests of adults.

7. How shall legal paternity be determined?

It is proposed that legal paternity in preconception arrangements be determined in the same manner as it is in other births.

As has been discussed in Part 2,⁴⁵ Ontario family law presumes that the husband or common law husband of a mother is the child's father.⁴⁶ That presumption prevails unless rebutted on the balance of probabilities with evidence of blood tests.⁴⁷ By presuming that the father is the man who has an intimate relationship with the mother, this principle of family law aims to recognize existing conjugal units and their value for child-rearing. The rule also permits a man willing to acknowledge and take responsibility for the child to challenge the presumption. The presumption and the possibility of rebutting it both serve the interests of the child in identifying a man to whom the law will attach the duties of fatherhood.

8. How should custody be decided in the event of a dispute concerning a commissioned child?

If, despite a legislative policy of discouragement embodied in these proposals, a child is commissioned and born under an agreement and is the subject of a custody dispute, the mother should have custody of the commissioned child unless, based on clear and convincing evidence, it is in the best interests of the child to be reared by another person.

Because a carrying woman would in all cases be considered the legal mother of a commissioned child, any custody contest would be between the legal mother and the sperm provider. If the sperm provider established his paternity at law, then the contest would resemble other custody battles in being between the legally recognized mother and father. There are, however, significant differences that justify a high standard of proof (i.e., the existence of clear and convincing evidence)⁴⁸ before a court should order that the child be removed from its mother.

In ordinary custody battles, it is rarely true that the child was deliberately conceived to separate it from one of its legal parents. Because (among other reasons) this is the purpose of a preconception arrangement, the proposed legislative policy is to discourage the practice. This policy might be defeated were it possible for fathers to sue for custody in the ordinary way. The reason is that a custody dispute between a commissioning man and a carrying woman would, as the available statistics suggest, almost always pit older, more affluent, and better educated fathers against younger, less affluent, and less educated mothers.⁴⁹ The socioeconomic advantages of a commissioning man might be viewed by the judge as evidence that the child's interests would best be served by being reared in his home. Thus, relying upon their material and educational advantages to gain custody, commissioning men would not be

discouraged by the unenforceability of the preconception agreement itself. To prevent the very characteristics that make women vulnerable to agreeing to a preconception arrangement (i.e., their relative youth, poverty, and limited education) from being the reasons that they cannot renounce the agreement, it is proposed that there exist a strong legal presumption in favour of the carrying woman's custody of the child.

This presumption would also serve the child's interests, for there is a second important way in which preconception arrangements differ from ordinary custody battles. Rarely does an ordinary custody battle concern a newly born infant; usually both parents have developed a relationship with the child, and the child with them. In a preconception arrangement, only the mother (and perhaps also other members of her family) will have developed a relationship with the child prior to birth. This relationship is significant, if not essential, to a child's very survival.⁵⁰ The importance of maintaining existing relationships is recognized in the statutory test for determining a child's best interests in a custody dispute. As we saw in Part 2,⁵¹ to resolve such a case, an Ontario judge must consider "the love, affection and emotional ties between the child and each person seeking custody ... [and] other members of the child's family who reside with the child."⁵² Given that an infant is usually best cared for by its mother, with whom it has the strongest relationship, it should be very difficult for a father to succeed in persuading a court that the child's best interests would be served by taking the infant from its mother.

9. May the non-custodial parent have access to the child?

To make clear that existing legislation applies also to preconception arrangements, it is proposed that legislation specifically state that parental entitlement to access is unaltered by the fact of a preconception arrangement.

Under Ontario family law, the fact of living apart does not deny parents the right of access to their children.⁵³ This entitlement includes the right to visit with and be visited by the child and the same right as the custodial parent to make inquiries and to be given information as to the health, education, and welfare of the child.⁵⁴ However, the right of access is not absolute. It is granted by court order only in the best interests of the child.⁵⁵

Thus, a commissioning man who is recognized as the legal father and who does not have custody of the child may seek access. It is not certain, however, that access will inevitably be granted. Given that the mother and father of a commissioned child will not usually have had an intimate or otherwise personal relationship but merely a commercial one, and given also that the mother's refusal to relinquish her child might have created animosity, the father's continued presence in the mother's life might cause considerable disruption to her and to her relationships with the child, her partner, and other children. This disruption might be harmful to the commissioned child and ought to be an important factor to be considered

in a decision as to whether access by the commissioning man will serve the child's best interests.

10. May the non-custodial parent be required to pay maintenance for the child?

Legislation should make apparent that the financial obligations of parenthood exist also in the case of a preconception arrangement.

Ontario law states that "Every parent has an obligation to provide support, in accordance with need, for his or her unmarried child ... to the extent that the parent is capable of doing so."⁵⁶ The Supreme Court of Canada has affirmed that a child's right to financial support from its parents is a right that inheres in the child; a parent "cannot barter away his or her child's right to support."⁵⁷ Thus, a parent's financial obligations are unaffected by a preconception arrangement. Both mother and father have a legal duty to support their children "in proportion to their respective incomes and ability to pay."⁵⁸ Since the practice of preconception arrangements tends to encourage poor women to have children by wealthy men,⁵⁹ the resulting child will likely require financial support from its father. This right cannot be waived by the child's parents in any agreement between themselves.

Discussion

The 10 specific proposals presented here are based on the view that preconception arrangements constitute a social practice of procreation, which, like other such practices, is the subject of family law. That the practice can be discouraged by applying existing family law and principles derived therefrom demonstrates that aspects of the practice that are likely to cause harm (such as, for example, the offering of financial inducements to a mother to part with her child) have already been foreseen and rendered unlawful by family law. The embodiment of these proposals in legislation would make it abundantly clear that preconception arrangements are governable by the rules that apply to every other birth.

The practical effect of this proposal would be to discourage the practice of preconception arrangements. Commercial brokerage agencies would be prohibited from operating and thus promoting the practice. Prospective commissioners, forbidden from offering payment, would be unlikely to find a carrying woman. Even if a woman agreed to enter an arrangement without payment, she would be considered the legal mother of the child irrespective of the origin of the ovum and, as the mother, she would be entitled to custody. If she chose not to relinquish her child, the commissioning man (assuming he could achieve recognition as the legal father) could gain custody only by presenting clear and convincing evidence that the child's interests required the child to be taken from its mother. Provided that he established his legal paternity, the commissioning man would have the other rights and duties of fatherhood, such as the right to seek but not necessarily to be granted access, and the financial obligation to support his child.

Among the advantages of this proposal is that it draws upon existing law to prevent harm and to discourage harmful activity. Moreover, the rules are uniformly applicable. There would be no exceptions for arrangements made, for example, in the context of a family, because exploitation can exist there as well as in the commercial world, and the harm to a mother and child from separation is not eliminated if the child is taken by a family member.⁶⁰ In relying upon existing law, the proposal would not ban unpaid and non-commercial arrangements, but it would assure mothers and children in such arrangements the same protection that the law affords every other mother and child.

The result of this proposal might appear harsh to persons who deeply wish to have a child to rear by means of a preconception arrangement. Whilst acknowledging the suffering of prospective commissioners, this proposal rests on the belief that the social problems of infertility and childlessness are not new. The law has not hitherto considered these problems to be sufficient to justify a market model of procreation or the commodification of women's reproductive capacities and of children themselves. There is no reason for the law to do so now.

Conclusion

In this part, we have rejected a market production model of procreation in favour of a developmental approach, which finds expression in family law. Family law has foreseen the harmful consequences of certain aspects of preconception arrangements and has legislated against them. Based on this body of law and a policy of discouragement, this part has presented 10 specific recommendations to be embodied in legislation specifically applicable to the practice of preconception arrangements. The practical effect of this proposal would be to discourage the practice. The purpose of discouragement is not to increase the suffering of the infertile and childless, but rather to prevent harm to women, children, and society in general.

Part 6. Legislation and Law Reform Proposals in Four Nations

Introduction

This study has proposed legislation that would render void and unenforceable any preconception arrangement whether paid or unpaid, and make illegal paid agreements and the commercial activity of brokers. This proposal is advocated for three reasons:

1. it would, by discouraging the practice, be likely to prevent the significant, harmful, and potentially harmful effects of preconception arrangements on parties and non-parties alike;

2. it would accord with a developmental approach, rather than a market production model of procreation, and thus respect human dignity by preventing the commodification of children and women's reproductive capacities; and
3. it would accord with the principles of family law (analyzed in the context of Ontario law) that already govern the activities that are central to preconception arrangements.

Having proposed legislation, this report now considers how other common law jurisdictions have legislated or considered legislating on the subject, to demonstrate the legislative trend in preconception arrangements. By canvassing statute law and (in its absence) law reform proposals in three nations — the United Kingdom, Australia, and the United States — this part shows that most common law statutes and proposals, like the proposal made here, aim to discourage the practice by banning its monetary aspects and rendering void the agreements themselves. Therefore, were Canadian provinces to adopt legislation similar to that which this study recommends, they would be acting in accordance with the majority of common law jurisdictions surveyed here.

United Kingdom

The Surrogacy Arrangements Act 1985

In January 1985, in response to the national outrage engendered by a preconception arrangement between a British carrying woman and American commissioners,¹ and by the notion that British babies should be available for export to the United States,² the government of the United Kingdom "resolved that new legal safeguards [were] needed" and decided to bring forward with the least possible delay "legislation to prevent the commercial exploitation of surrogate motherhood."³ The government quickly tabled a bill to outlaw the practice of making commercial preconception arrangements. During the second reading of the bill in the House of Commons, the Secretary of State for Social Services, Norman Fowler, stated that the bill was a limited measure and that the government intended to deal more fully with the issue in subsequent legislation.⁴ (The government did so, five years later, in the Human Fertilisation and Embryology Act 1990, c. 37.)⁵ The 1985 "limited measures" bill rapidly passed through the House of Commons, received Royal Assent on 16 July 1985, and came into force on that day. It is entitled the Surrogacy Arrangements Act 1985.

The Act prohibits the operation of commercial surrogacy agencies, the advertisement of the services of carrying women and brokers, and the advertisement of the desire of a commissioning couple to engage such services. In these respects, the Act uses the criminal law to ban the commercial practice of brokering preconception arrangements but does not prohibit not-for-profit brokerage agencies or paid arrangements. Nor does the Act make any provision regarding the enforceability of preconception

arrangements. By not prohibiting payment by commissioning couples to carrying women, the Act arguably fails to protect carrying women from the exploitation that can accompany the offer of payment in exchange for a child.

The Act defines a "surrogate mother" to be a woman who carries a child in pursuance of an agreement made before she began to carry the child, and with a view to relinquishing her maternal rights to it.⁶ This definition includes any arrangement a woman makes before conception to surrender her child at birth. The origin of the gametes is irrelevant. The section would therefore catch the types of arrangements described by one British commentator⁷ whereby a husband and wife agree to conceive a child that the woman will carry for surrender to a person or couple at birth. These arrangements differ from more common arrangements in that the person or couple intending to receive the child has no direct genetic connection to the child (though one of the commissioning people might be a sibling or other relative of the genetic man or the carrying woman).

One of the central purposes of the Act is to prevent third parties from deriving a financial benefit from preconception arrangements. Thus, it is an offence for a person to do, or knowingly cause another to do, certain acts on a commercial basis. The three prohibited acts are to:

- (a) initiate or take part in any negotiations with a view to the making of a surrogacy arrangement;
- (b) offer or agree to negotiate the making of a surrogacy arrangement; or
- (c) compile any information with a view to its use in making, or negotiating the making of, surrogacy arrangements.⁸

As stated, it is not an offence, under the Act, for the carrying woman or the commissioning couple to participate (without an intermediary) in a preconception arrangement on a paid basis. The Act does not, however, make provision for how payment to a carrying woman would be viewed by pre-existing U.K. law. The Adoption Act, 1958 makes it an offence in Sec. 50 for parties to make payment in connection with an adoption.

For the purposes of the Surrogacy Arrangements Act 1985, a person acts on a commercial basis if that person or another receives payment in respect of the act, or if it is done with a view to payment being received. There is no need to establish that payment has actually been made — the mere contemplation of payment is sufficient.⁹ Brokers will not be guilty of an offence if they can prove that they neither knew nor had reasonable cause to suspect a payment had been or was to be made to another person.¹⁰

The Act also attaches liability to corporations, managers, and shareholders. It is an offence for a "body of persons" to be intermediaries in preconception arrangements on a commercial basis and for a person in the United Kingdom to take part in the management or control of a body of persons involved in making commercial preconception arrangements.¹¹

Significantly, the Surrogacy Arrangements Act makes it illegal for anyone (brokers, commissioners, or carrying women) to advertise that any person is looking for a carrying woman, wishes to become a carrying woman, is prepared to enter a preconception arrangement, or is willing to negotiate or facilitate a preconception arrangement.¹²

Persons found guilty of brokering an arrangement are liable to a fine not exceeding level 5 on the standard scale as defined by the Criminal Justice Act 1982 (in 1985, £2 000), and/or a maximum term of imprisonment of three months. Those who unlawfully advertise may also be fined up to £2 000.¹³ Given the amount of money a commercial broker can make on each arrangement (in the 1985 case, the broker might have received £7 000), the amount of the fine appears too low to eliminate the practice.

The Act is deficient also in failing to address the central issue of enforceability. Are the arrangements illegal and void as against public policy or are they valid and enforceable contracts? In Sec. 1(9), the Act dodges the issue by stating, "This Act applies to arrangements whether or not they are lawful and whether or not they are enforceable by or against any of the persons making them."

It is possible to infer from this section that some arrangements are lawful and enforceable in whole or in part. Apparently the Minister for Health, Kenneth Clarke, resisted attempts to amend the section because he thought that in certain circumstances, parties ought to be able to rely on the agreement.¹⁴ He cited the example of a woman who stopped working in reliance on the commissioning couple's promise to reimburse her for lost earnings. The premise of the Act, *viz.*, that some provisions ought to be enforced and others not, is not principled because there are no clear criteria in the Act by which to decide which are valid and binding terms.

In summary, the Surrogacy Arrangements Act 1985, though hostile to commercial preconception arrangements, was hastily drafted and therefore has some defects. The Act deals only partially with the main problems to which the practice gives rise. In outlawing commercial brokering but not the actions of the principal parties, the Act contemplates that the practice will continue and that financial inducements to participate are permissible. It does not address the central issue of the parentage of the child, who is the most vulnerable person in the arrangement, and the respective rights and duties of the adult parties to the child whom the agreement seeks to bring into being.

Human Fertilisation and Embryology Act 1990

Five years after the enactment of the Surrogacy Arrangements Act 1985, the law related to preconception agreements was amended and clarified by the Human Fertilisation and Embryology Act 1990 (hereinafter HUFE Act).¹⁵ The Act deals with a much broader range of issues than those generated merely by preconception agreements. It is concerned with research involving, and the storage of, human embryos;¹⁶ abortion;¹⁷ access

to infertility services; preconception arrangements; and the status of the child resulting from techniques of artificial reproduction. What follows concerns the last two of these issues.

The HUFE Act amends the Surrogacy Arrangements Act 1985 by providing that "no surrogacy arrangement is enforceable by or against any of the persons making it."¹⁸ This provision makes clear that the arrangements are not "contracts" enforceable at law but mere promises of a social nature that do not give either party legal redress in the event of failure to honour the promise.

Although the HUFE Act deals directly with the question of enforceability of the arrangements, it does not address many of the other questions to which the practice gives rise. If the carrying woman decides not to surrender the child, may she be subjected to a custody battle of the type witnessed in the *Baby M* case? Will the commissioning man have access to, or be obligated to support, the child? Because the statute does not speak to these issues, it is arguable that they would be governed by the common law.

The Act extends the definition of surrogate mother contained in the Surrogacy Arrangements Act 1985 to include methods of becoming pregnant that were developed, or increased in use, since its enactment in 1985. The earlier act contemplated the commencement of pregnancy by sexual intercourse, artificial insemination, or embryo insertion (through, for example, IVF). The HUFE Act amends the 1985 Act by including the techniques of zygote intrafallopian transfer (ZIFT) and gamete intrafallopian transfer (GIFT).¹⁹ The definition clearly includes exclusively gestational arrangements in regulating preconception arrangements. Therefore, physicians and others attempting embryo and egg donation in pursuance of a preconception arrangement might be found in violation of the law if they operate these services on a commercial basis and these activities are held to constitute the initiation of a surrogacy arrangement²⁰ or the facilitation of the making of a surrogacy arrangement.²¹

The question of the status of children born of artificial reproduction (including preconception arrangements) has been addressed by the 1990 Act.²² The woman who carries and gives birth to a child in the United Kingdom is to be considered the child's mother irrespective of the origin of the ovum, unless the child has subsequently been adopted by another woman.²³ The Act also defines who shall be considered the child's father.²⁴

The effect of these status provisions on preconception arrangements in the United Kingdom is as follows:

1. The woman who carries and gives birth is considered the mother of the child, Sec. 27(1);
2. Her husband will be considered the father unless it can be shown that he did not consent to the insemination or transfer, Sec. 28(2);

3. The husband will, however, be the *presumed father* of the child according to the common law presumption that a child is the child of a marriage, unless the husband shows otherwise, Sec. 28(5); and
4. If the carrying woman was not married when she became pregnant, or if her husband did not consent to her becoming pregnant by those means, then the man with whom she received the infertility services whose sperm was not used, will be considered the father of the child, Sec. 28(3).²⁵

Thus, a commissioning man whose sperm was used, or a commissioning woman whose egg was used, would not ordinarily be considered the father or mother of the child and would not therefore have standing to seek custody of the child. But Sec. 30, a late amendment to the bill,²⁶ provides limited circumstances in which gamete donors can seek a "parental order." In other words, the legislation makes it possible for the commissioning couple in a preconception arrangement to be considered, at law, as the parents of the child, and to terminate the rights of the carrying woman. Under Sec. 30, a court may order that a child be treated as the child of a commissioning couple provided the following conditions are met:

1. The commissioning couple is married, Sec. 30(1);
2. The child was born of a carrying woman who conceived as a result of artificial insemination, or the transfer of sperm and eggs or of an embryo, Sec. 30(1)(a);
3. The gametes of the commissioning man and/or the commissioning woman were used, Sec. 30(1)(b);
4. The commissioning couple applied for the order within six months of the child's birth (or within six months of the Act coming into force), Sec. 30(2);
5. When the application was made, the child lived with the commissioning couple who was domiciled in the United Kingdom, the Channel Islands, or the Isle of Man, Sec. 30(3);
6. Both members of the commissioning couple are 18 years of age or older, Sec. 30(4);
7. The court is satisfied that the carrying woman and her husband, or the father of the child where the carrying woman's husband is not, by virtue of Sec. 28, to be treated as the father of the child, have freely and with full understanding of what is involved agreed unconditionally to the making of the order, Sec. 30(5);
8. The agreement of these persons is not required if the persons cannot be found, Sec. 30(6);

9. The agreement of the carrying woman is ineffective if given less than six weeks (42 days) from the date of the child's birth, Sec. 30(6); and
10. Unless authorized by the court, no money or other benefit (other than for expenses reasonably incurred) may be given or received by the commissioning couple²⁷ for or in consideration of (1) making the order; (2) any agreement by the mother or father, as defined by Secs. 27 and 28, to relinquish the child; (3) the surrender of the child to the commissioning couple; or (4) the making of any arrangements with a view to the making of the order.

Thus, commissioning couples may apply to adopt children born pursuant to a preconception arrangement. Provided that the carrying woman and her husband, or the person deemed to be the father of the child, consent on a day at least 42 days after the child's birth, they have been given no money or other consideration by the commissioning couple other than "expenses reasonably incurred," and the child is living with the commissioning couple who are married, the court may order that the commissioning couple become the adopting parents of the child. The result is that unpaid agreements may be given legal effect provided the carrying woman and the commissioners agree to seek legal endorsement of their arrangement after the birth of the child.

This section accords with U.K. case law in that if the woman who gives birth to the child is not willing to relinquish the child, the commissioning couple cannot be granted custody of the child.²⁸ It goes further, however, in establishing rights in the carrying woman's husband or the man otherwise deemed to be the father to refuse to relinquish the child for adoption, and in establishing criteria by which commissioners can gain legal parentage of commissioned children.

Australia

In Australia, the regulation of preconception agreements is a matter for which state and territory governments have primary constitutional responsibility. The Commonwealth government has a limited responsibility where such an agreement is an issue in family law proceedings involving the guardianship, custody, or access of children.

Although there have been no reported cases of litigated disputes involving preconception agreements, the practice does take place in Australia in both its genetic-gestational and exclusively gestational forms. Commercial brokers appear not to be involved but some of the carrying women are paid.²⁹

Each of Australia's six state governments has studied the issue of preconception agreements for the purpose of making law in respect of it. In addition, two Commonwealth committees have made recommendations

for federal legislation. With the exception of the now-disbanded National Bioethics Consultative Committee, each committee has denounced the practice and encouraged prohibitory legislation. Such legislation, which varies in the degree to which it bans the practice, has been enacted in Victoria, Queensland, and South Australia, and will likely soon be passed in Western Australia.³⁰

Statutes

Victoria

The Infertility (Medical Procedures) Act, 1984³¹ broadly defines a surrogate mother as one who agrees in advance of conception or during pregnancy to surrender her child to another person irrespective of whether she receives payment.³² Such agreements are void.³³ Under the statute it is a criminal offence to publish an advertisement to induce, seek, or offer the services of a woman to act as a surrogate mother.³⁴ It is also a criminal offence to receive payment to act as a surrogate mother or broker, or to give payment to either of these parties. The sanctions for these criminal offences are 50 penalty units or two years' imprisonment.

Thus, in Victoria, arrangements for the surrender of children are permissible provided that the parties do not advertise and no payment or reward is given or received.

Queensland

Of the three Australian states that have legislated concerning the practice, Queensland is the most strongly prohibitive. The Surrogate Parenthood Act, 1988³⁵ defines a "prescribed contract" as one in which a woman agrees before conception, or during gestation, to surrender her child to another person or persons irrespective of whether she is paid or otherwise rewarded. The Act makes it a criminal offence to enter, or to offer to enter, into a "prescribed contract."³⁶ It is also an offence to give or receive payment for, or in consideration of, a person entering into such an agreement.³⁷ Further, the Act makes criminal advertisements to induce, seek, or offer the services of a carrying woman, or stating that a person is willing to enter into a "prescribed contract."³⁸ The Act applies to non-residents of Queensland who do the prohibited acts in Queensland, and also to residents of Queensland who go outside the state to do the prohibited acts.³⁹ The "prescribed contracts" are illegal and void. No action may be brought to enforce such an agreement or to recover any money or thing paid in connection with a "prescribed contract."⁴⁰ The penalty for doing the prohibited acts is 100 penalty units, three years' imprisonment, or both.

Queensland is unique among the three Australian states that have passed legislation on the issue in making it a criminal offence for carrying women to enter into a preconception arrangement even when they are not paid to do so.

South Australia

South Australia's Family Relationships Act Amendment Act, 1988⁴¹ is less prohibitive of the practice. It distinguishes between the agreement between the carrying woman and the commissioners (the *surrogacy contract*)⁴² and the agreement between the commissioners and the broker (the *procurement contract*).⁴³ Each of these agreements is illegal and void.⁴⁴ The Act makes it a criminal offence to enter a procurement contract for payment or reward,⁴⁵ or to induce another to enter into a procurement contract having received, or in the expectation of receiving, payment from a third party who will receive the benefit of the agreement.⁴⁶ This prohibition is directed against commercial brokers and commissioners entering into agreements with such brokers. It does not affect the actions of a woman who receives money to carry and surrender a child nor the actions of commissioners in paying her. The Act also makes it a criminal offence to advertise that a person wishes to enter, is seeking a person wishing to enter, or is willing to broker a "surrogacy" arrangement.⁴⁷ The penalty for doing the prohibited acts is \$4 000 (Australian) or 12 months' imprisonment.

Therefore, South Australia is the least punitive of the three states. It makes criminally illegal the commercial operation of surrogacy brokers and advertisement in connection with agreements. Although the agreements are rendered illegal and void by the act, there is no criminal prohibition against commissioning couples making, and carrying women receiving, payment to enter these arrangements provided they do not advertise.

Proposals for Law Reform

Tasmania

In 1985, the Committee of Inquiry to Investigate Artificial Conception and Related Matters in Tasmania (Chair: Mr. Don Chalmers) published its *Final Report*. It recommended, after weighing the arguments for⁴⁸ the practice with those opposed,⁴⁹ that preconception arrangements be considered as unacceptable at that time, but that the practice should be reviewed in five years of the date of the report. The committee suggested there might be some situations in the future for which a preconception agreement could be an acceptable option, but that regulations would be required to ensure the best interests of the child. Such regulations should be introduced by specific legislation, and the Department of Community Welfare should implement them. The committee recommended counselling for all involved parties as an important prerequisite for any potential preconception arrangement.

Western Australia

The committee appointed by the Western Australia Government to inquire into the social, legal, and ethical issues relating to IVF and its supervision (Chair: Professor C.A. Michael) only briefly considered preconception arrangements in rendering its 1986 report.⁵⁰ It accepted the

reservations expressed in the reports of other government-appointed committees and professional bodies and recommended that preconception arrangements should not be permitted or recognized as an acceptable procedure for the alleviation of infertility.

In 1988, a second Western Australian committee, the Reproductive Technology Working Party, was convened under the chairmanship of Mr. M. Daube to make specific legislative recommendations to the minister of health.⁵¹ It concluded that preconception arrangements are undesirable because they disrupt the bond between the parent and child; they cause emotional, psychological, and physical problems for the mother and child; and they involve a third party in a preconception arrangement, which, in their opinion, is contrary to public policy and unlawful. The working party recommended that specific legislation be enacted, criminal sanctions be introduced against commissioning parents and their agents in commercial agreements, and the Family Court Act be amended so that the carrying woman could recover the costs of the pregnancy and birth from the commissioning parent(s) of that child, just as other mothers of ex-nuptial children can recover costs from the child's father.

Later that same year, a third Western Australian committee was convened to examine the second committee's report. The Select Committee to Inquire into the Reproductive Technology Working Party's Report published its recommendations in December 1988.⁵² It endorsed the earlier committee's views as they applied to preconception arrangements and reaffirmed the undesirability of the practice. In particular, the third committee emphasized that the primary intention of legislation should be to "reduce the likelihood of entrepreneurial involvement in surrogacy contracts and arrangements." It also recommended that the proposed Reproductive Technology Council should address the issues of the relationship of carrying women to reproductive technology.

New South Wales

In 1988, the New South Wales Law Reform Commission published the last of its three reports on artificial conception: *Artificial Conception: Surrogate Motherhood Report*.⁵³ Based on its research and public submissions, the commission recommended that the practice of making preconception agreements should not be actively approved or encouraged by the government, but that it should not be totally prohibited because this would be unjust and difficult to enforce. It recommended that commercial and paid arrangements be prohibited and that anyone who knowingly assists or advertises a preconception arrangement be subject to criminal sanctions. Further, it recommended legislation to declare the agreements void and unenforceable, and that the carrying woman be conclusively presumed to be the legal mother of the child, irrespective of whether she is genetically related to the child. Based on the principle that the welfare of the child should be the paramount consideration, the committee recommended that adoption should not be automatically available to commissioners.

It is interesting that the committee also recommended a public education campaign in conjunction with appropriate counselling to persuade infertile couples against resorting to preconception arrangements.

The committee's recommendations were based on the conclusions of its inquiry, which were that preconception arrangements provide an unacceptable answer to infertility because:

1. the child and carrying woman are separated at an early age;
2. the body of a woman is put to the use of the commissioning couple; and
3. there is no guarantee that the carrying woman and the commissioning woman have free choice as both risk pressure to comply even in unpaid arrangements.

Commonwealth Government

The Commonwealth government received two reports, one in 1985 and the other in 1990, with very different recommendations.

The Family Law Council in its 1985 report, *Creating Children: A Uniform Approach to the Law and Practice of Reproductive Technology in Australia* (Chair: Mr. Justice Asche),⁵⁴ considered at length the issues surrounding preconception agreements and the conclusions reached by a number of committees, notably the Waller,⁵⁵ Demack,⁵⁶ and Warnock⁵⁷ committees. Having considered these opinions, the committee recommended that the state should not permit preconception arrangements but carrying women and commissioning couples should not be subject to a criminal penalty. However, brokers and others assisting an arrangement should be subject to the sanctions of the law.

The committee rejected the argument that women should be free to use their bodies as they wish and to enter preconception arrangements. They concluded that this argument fails to take account of the fact that preconception arrangements involve a third party — the child — and that a child's interests would not be served by such an arrangement. The committee also argued that permitting preconception arrangements would institutionalize the practice and its attendant exploitation and other problems. It recommended that the practice be seen as contrary to the welfare and interests of the child. In addition, it recommended there be a prohibition of the exchange of money or benefits for preconception arrangements, for arranging carrying services, and for advertising such services. The committee also advocated that preconception arrangements be declared null and void because they are contrary to public policy and therefore unenforceable, and that complete uniformity between the states and territories be established in respect of these matters.

Unlike other legislation and legislative proposals in Australia, a second Commonwealth committee recommended that the law endorse preconception arrangements under certain conditions. The National Bioethics Consultative Committee (NBCC) was established in 1983 by the

Australian federal government to advise state and federal governments, through its health minister, on the social, ethical, and legal issues arising from reproductive technology. It was asked by the Council of Social Welfare Ministers (which comprises ministers from the Commonwealth and each state and territory) to examine the issue of preconception arrangements.

The NBCC's first report was published in April 1990 under the title *Surrogacy: Report 1*.⁵⁸ In it, the NBCC considered the following principles to be relevant to a consideration of the practice:

1. The principle of personal autonomy or self-determination, i.e., that a couple should, as far as possible, be free to make their own procreative arrangements to form a family as long as this does not involve harm to others; similarly, that a woman should be free to make decisions about the use of her own body to gestate a child for another as long as this does not cause demonstrable harm to others.
2. The principle of justice, i.e., that all those involved in preconception arrangements should be treated justly and fairly. In particular, this means that the best interests of the carrying woman and any child born as the result of a preconception arrangement should be safeguarded. The NBCC recognized that the interests of the child become paramount if dispute exists over custody, but this situation is not peculiar to preconception arrangements.
3. The principle of the common good, i.e., that society has a stake in ensuring, as far as possible, that parent-child relationships are established in an orderly way.⁵⁹

The majority of the NBCC agreed that there was a need for appropriate and necessary uniform legislation to govern the practice, which it viewed as neither immoral nor anti-social and therefore permissible. The majority recommended, therefore, that the practice should be permitted but under strictly controlled uniform legislation, which would render all arrangements unenforceable and would include controlling mechanisms for agencies and advertising controls.⁶⁰

However, two members (Heather Dietrich and Sister Regis Mary Dunne) wrote dissenting opinions in which they advocated total prohibition.

In her particularly powerful dissent, Sister Dunne decried the majority view for its narrow application of the principle of personal autonomy, its treatment of women and children as commodities, and its disregard of the injustice done to them; its incorrect view of the practice as medical treatment; and its lack of appreciation of the impact of the formal establishment of preconception agreements on public policy, which, she argued, is an instrument of cultural change.⁶¹

Notwithstanding this dissent, the NBCC issued a second report, *Discussion Paper on Surrogacy 2 — Implementation*, in October 1990.⁶² It aimed to establish a system to enable

private individuals considering surrogacy as a means of family formation to access accurate information and counselling services under strictly controlled circumstances. These options aim to assist people to make informed decisions about the appropriateness of surrogacy for them.⁶³

The paper included draft model legislation that would create a system for controlling the practice, and make provision for the establishment of an agency to supervise the making of preconception arrangements; the purpose of the agency would be to ensure that participants engaged in detailed discussion of the implications of the proposed arrangements and that the process was open to public scrutiny and accountability. The proposed statute envisaged that carrying women would be paid, but did not state any minimum or maximum amount. Money owed by commissioners would be held in trust by the agency that would make payments to the carrying woman in accordance with the terms of the agreement. Further, the draft statute provided that legal parentage would automatically vest in the commissioning parents one month after the birth of the child, so long as the carrying woman did not object, in writing, before that time.

In March 1991, the Council of Social Welfare Ministers rejected the recommendations of the NBCC that preconception arrangements should be allowed in Australia under strict controls. The council decided instead that the states and territories should legislate to make preconception arrangements void and unenforceable. The council cited the exploitation of the women and children involved in preconception arrangements as the main reason that such arrangements should be banned.⁶⁴

Not only were the NBCC's recommendations soundly rejected, the NBCC itself was disbanded. "In the wake of a stunning defeat of the NBCC's proposals to legalize and regulate surrogate motherhood,"⁶⁵ the federal Minister for Community Services and Health, Brian Howe, dissolved the NBCC and transferred responsibility for advising the government on bioethics issues to the National Health and Medical Research Council.

There is, at this writing, no draft federal legislation to ban preconception arrangements as the result of the resolutions of the Council of Social Welfare Ministers. However, proposed legislation to prohibit the arrangements might be modelled on the provisions of the statutes already enacted by Victoria, Queensland, and South Australia.⁶⁶

United States

Statutes

The trial decision in the *Baby M* case in early 1987 focussed public attention in the United States on preconception arrangements. As a consequence, between 1987 and 1990, 13 states passed legislation to govern the practice.⁶⁷ The statutes vary in the degree to which they treat the subject: some consider the matter tangentially and others comprehensively. More significantly, the statutes vary in the approach they

adopt toward the agreements. Approaches range from criminal prohibition, to civil unenforceability, to regulation.

Criminal Prohibition

States that criminally prohibit preconception arrangements prohibit only paid and commercial arrangements. Five states have passed legislation making it a criminal offence to enter into or broker a paid preconception arrangement: Arizona,⁶⁸ Kentucky,⁶⁹ Michigan,⁷⁰ Utah,⁷¹ and Washington.⁷² Arizona bans not only paid but also unpaid arrangements and, although it refers to "crimes," it provides no penalty. Violation of the Kentucky prohibition to participate in or to facilitate a paid preconception arrangement results in a penalty under the Kentucky child-selling statutes of a fine of \$500 to \$2 000 or a sentence of not less than six months' imprisonment or both. In Utah⁷³ and Washington, an offence is a Class A misdemeanor and gross misdemeanor, respectively.

The efforts of Michigan to make the paid and commercial practice of preconception arrangements criminally illegal have met with mixed success. The legislation passed in 1988 made it a crime to enter into a paid preconception arrangement and provided a penalty of \$10 000, one year in prison, or both. A person who brokered such an arrangement would be liable to a penalty of \$50 000, five years in prison, or both.⁷⁴ This legislation was challenged, however, by broker Noel Keane⁷⁵ and the American Civil Liberties Union (ACLU), who claimed it was unconstitutional. They argued that the legislation impermissibly limited an infertile couple's right to privacy in conceiving a child, and that it violated their rights to equal protection because it would permit artificial insemination where a husband is infertile but not preconception arrangements where the wife is infertile.⁷⁶ In his declaratory ruling rendered 9 November 1988, John Gillis, Circuit Judge, held that the legislation was constitutional if it was read to permit paid preconception arrangements provided that payment is not contingent on relinquishment. In response to this ruling, a bill was introduced in the Michigan Senate in February 1989 that would deem all paid preconception arrangements to entail compensation for relinquishment of the child. This bill would therefore nullify the effect of the Keane/ACLU intervention and make all paid preconception arrangements illegal in Michigan.⁷⁷

Unenforceability of Agreements

A second group of state statutes did not make the practice criminally illegal but sought to express disapproval of it by stating that preconception arrangements are unenforceable. Louisiana⁷⁸ and Nebraska⁷⁹ legislated that paid preconception arrangements are void; Indiana⁸⁰ and North Dakota⁸¹ made both paid and unpaid agreements unenforceable. Louisiana did not carry on to consider who would be considered the legal parents of the child. Nebraska appears to assume the carrying mother will be considered to be the legal mother and specifically states that the biological father, usually the commissioning man, will have all the rights and obligations imposed by law, which presumably include visitation (if not also

custody) and obligations to support the child financially even if he does not have custody. North Dakota states that the mother of the child is the woman who gave birth and the father is her husband provided she is married and he is party to the arrangement. Indiana would have parentage determined, in the event of a dispute, not with reference to the arrangement, but according to the best interests of the child.

Tangential Consideration

A third set of state statutes appears to allow preconception arrangements, but legislate in a very cursory way. Arkansas⁸² has passed a statute related to preconception arrangements but it is principally concerned with artificial insemination. It states that in a preconception arrangement using artificial insemination, the resulting child is presumed to be the child of the biological father and intended mother. This statute does not deal further with preconception arrangements — their legality, their enforceability, or the extent to which people may participate in or broker them for payment.

Similarly, Nevada does not deal comprehensively with the issue. It exempts from its statute prohibiting payment for adoption "lawful contract[s] to act as a surrogate and give birth to the child of a man who is not her husband." Unfortunately, the statute does not define "lawful contract," so it is unclear whether paid and commercial arrangements would be permitted in Nevada.

Regulation

A fourth and final set of statutes regulate the practice of preconception arrangements. Both Florida⁸³ and New Hampshire⁸⁴ have devised legislative schemes by which participants might lawfully participate in a preconception arrangement. The Florida scheme appears designed primarily to protect the child; the New Hampshire statute appears concerned with protecting both the child and the carrying mother.

The 1988 Florida statute makes commercial preconception arrangements illegal but specifically allows parties to enter into arrangements, which it terms "preplanned adoption arrangements." A carrying woman may be paid expenses incurred in participating provided payment is not contingent upon her relinquishing the child. Such arrangements are not enforceable and must contain certain terms. These include the "volunteer mother's" assent to become pregnant by the "fertility technique" (which does not include sexual intercourse) specified in the agreement; and to bear, deliver, and then relinquish the child subject to her right of rescission, which may be exercised within seven days of the child's birth. She also agrees to submit to "reasonable medical evaluation," presumably before conception, to determine whether she will be able to carry a pregnancy to term, and to adhere to reasonable medical instructions about her prenatal health. The agreement must also specify that the carrying woman will assume responsibility for the child if the commissioners terminate the agreement before they receive the child.

The commissioning man, who is also the biological father, must agree to assume parental rights and responsibilities for the child if the agreement terminates in advance of transfer. This would mean that if the commissioners decide not to accept the child, the carrying woman would legally be considered its mother, and the commissioning man, as its legal father, would be obligated to pay child support and might also have rights of access. The commissioners would be allowed to pay the carrying woman "all reasonable legal, medical, psychological or psychiatric expenses ... related to the preplanned adoption arrangement, and may agree to pay [her] reasonable living expenses."⁸⁵

The commissioners must agree to accept the child even if it is born with a handicap, but they may require the carrying woman to submit to blood and tissue-typing tests to determine that at least one of the commissioners is a genetic parent. This last provision would likely enable commissioners to refuse to accept a child that is not genetically related to at least one of the commissioners.

There are certain terms that may not be contained in a "preplanned adoption agreement." There may not be a clause reducing the amount paid to the carrying woman if the child is stillborn or handicapped, or requiring the carrying woman to have an abortion. The carrying woman and the commissioners must be separately represented by legal counsel, who may not receive payment in excess of "reasonable compensation for their professional services." No one may receive a broker's fee.

Although the Florida statute prohibits preconception arrangements accompanied by payment beyond expenses and specifically enables a woman to resile from the agreement, it does not prevent the potential exploitation of a woman in problematic financial and psychological circumstances who agrees to participate as a carrying woman and the harm to her and her family of losing the commissioned child. By offering a woman reasonable living expenses, commissioners may induce impoverished women, especially those with other children to support, to enter into a preconception arrangement. Although the statute specifically states that a woman may refuse to relinquish the child, the onus is on the carrying woman to refuse to relinquish within seven days or to assert at the adoption hearing that she was unaware of her right to rescind. Given the imbalance in power that typically exists between carrying women and commissioners, and the sense of loyalty to the commissioners that carrying women often feel,⁸⁶ the requirement of a positive act to keep her child might not adequately protect a woman who genuinely wishes to rear the child. Further, the statute does not require the commissioners to undergo any screening or home study to ensure they are in fact a couple or a married couple as the statute presumes and that the child will be transferred into a loving environment. The statute appears to be directed against the possibilities that women will be exploited economically and that the child will be rejected by both mother (carrying woman) and father (commissioning man). The statute does not discourage the practice and its attendant

harms, and it fails to protect women against state-enforced surrender of their children, and children against being transferred from their mothers into homes that are not good for them.

The New Hampshire statute,⁸⁷ which also regulates the practice of preconception arrangements, appears to have been drafted with somewhat more sensitivity to the vulnerabilities of all the parties; it aims to "establish consistent state standards and procedural safeguards for the protection of all parties, and to determine the legal status of the children born as a result of these arrangements."⁸⁸ It does not, however, take adequate account of the imbalance of power typically existing between commissioners and carrying women, and the potential harmful effects of participation on the carrying woman, the commissioned child, the carrying woman's other children, her husband, her parents, and the commissioning woman.

The New Hampshire statute makes both paid⁸⁹ and commercial⁹⁰ arrangements illegal as well as any unpaid non-commercial arrangement that does not receive court approval in advance of conception and in accordance with the statute. The statute requires that, to be eligible to participate in an approved arrangement, all parties must be at least aged 21; the commissioners must be married to each other; the commissioning woman must be medically determined to be physiologically unable to bear a child without risking her health or the child's; a carrying woman must already have given birth to a live child; and a gamete of the commissioning man or woman or both must take part in the conception. Further, all the parties are required to be psychologically evaluated to determine whether they can adjust to and assume the inherent risks of the arrangement, and whether, if commissioners, they can "give a child love, affection and guidance."⁹¹ A home study of the commissioners' home must be conducted by a licensed agency to determine whether the commissioners are able and willing to provide materially for the child.

Evidence of eligibility and evaluation according to the foregoing criteria is required to be submitted to the court for authorization of the arrangement before conception. A copy of an executed proposed arrangement must be submitted and contain the following terms:

1. that the carrying woman agrees to relinquish the child or to become its legal mother if she decides to keep the child;
2. the consent of the carrying woman's husband, if any, to surrender the child or to become its legal father if his wife decides to keep the child;
3. the consent of the commissioners to assume the legal obligations of parenthood should the carrying woman relinquish the child;
4. that the carrying woman has the right to retain the child if, within 3 days of the child's birth, she "executes a signed writing of her intention to keep the child and delivers the writing to the [commissioners], the attending physician, or the hospital medical director or designee." This document may be executed only by the

- carrying woman and only within 72 hours of giving birth unless there are extenuating circumstances preventing her "from making an informed decision" in which case the period is one week; and
5. that payment is limited to medical expenses, actual lost wages, insurance, legal fees, and counselling and evaluation fees.⁹²

The agreement may not require a woman to have an abortion, or forbid her to have an abortion.⁹³ All decisions regarding the health of the carrying woman and the fetus shall be made by the carrying woman.

The statute operates from the unarticulated premise that the physical inability of a married couple to have a child themselves is a reason to obtain one by using the body of a willing adult woman, with the consent of her husband if she is married. By eliminating the possibility of payment beyond expenses, and of the participation of brokers, the statute aims to reduce the possibility of economic exploitation. By enabling a woman to resile from the agreement within three days of giving birth, the statute attempts to protect a woman from being compelled to relinquish a child that she wishes to rear. And by specifying who will have legal responsibility for the child if it is retained by the carrying woman or relinquished to the commissioners, the statute endeavours to protect the child.

Yet, the statute does not adequately attend to the fact that a woman's "choice" to enter into a preconception arrangement and to relinquish the child might be made in circumstances that are problematic for financial and psychological reasons. For example, she might be asked by her employer to become pregnant by and for him. Or, once pregnant, she might care about the commissioners and therefore not wish to cause them further suffering; and yet she might deeply desire to keep the child. If she is in this state of ambivalence and if the commissioners are constantly in her hospital room with her and the baby, she might find it enormously difficult within three days of giving birth to take the positive act of renouncing the arrangement. Moreover, though the statute requires that the carrying woman be evaluated to determine whether she is able "to adjust to and assume the inherent risks of the contract," it is not clear that the woman or a psychologist or psychiatrist can know in advance what the long-range effects of relinquishment will be on that particular woman.

To be sure, persons who undergo medical procedures for their own or another's benefit in a life-threatening situation confront the same problem of assuming risks in the face of uncertainty, but, here, there is no threat to life. Nor is there any convincing justification for creating a situation in which a person promises to undergo a bodily process that has well-documented physical risks and less well documented psychological risks, without a clear benefit to herself — for the statute does not even contemplate that the birth mother might continue her relationship with the child if she surrenders it to the commissioners. Further, the statute does not take into account that relinquishing the child might seriously and harmfully affect the carrying woman's other children, her parents, and her

husband, whose consent does not prevent him from being harmed. Nor does the statute address the commissioning woman's position in the arrangement, which might be to agree reluctantly and through fear that, were she to thwart her husband's desire to have a genetically related child by this means, she would lose him.

To assent to this sort of regulation is to assent to the notion that the production of children can be commissioned lawfully, provided the producers meet certain specifications; it is to approve of the state's participation in the business of a woman agreeing in advance of conception to terminate her relationship with the child of her body. The very act of passing legislation of this sort — even to prevent harm and to engage in damage control — conveys a public message that the activity is to be encouraged within specific bounds and that, within those bounds, it is acceptable. The good that the New Hampshire statute attempts to do is to protect innocent parties who wish to place a child in the home of commissioners who are usually socioeconomically advantaged. In so doing, however, the child is taken from the home of the mother, who is usually socioeconomically disadvantaged. Not only does the state thereby sanction the transfer of children from less wealthy to wealthier homes, the state participates in family break-up. Unlike adoption, where the state becomes involved after (a usually unintended) conception, and in the interests of the child, here the state of New Hampshire facilitates the intended loss of a child by its birth mother and her family, and the loss of its mother by a child. These losses, approved by the state in advance of conception when they might be prevented, are suffered not in the interests of the child but in the interests of the commissioners. To assent to the New Hampshire statute is to assent to its unarticulated reliance upon a production model of procreation and its assumption that a social practice of procreation that intends family break-up is worthy of state recognition.

Proposals for Law Reform in New York and California

New York Proposals: The Dunne Report and the New York State Task Force on Life and the Law

There have been two official considerations of preconception arrangements in the state of New York.⁹⁴ The first was that of the New York State Judiciary Committee under the chairmanship of Senator John R. Dunne.⁹⁵ It recommended in January 1987 that the legislature adopt a regulatory scheme involving judicial authorization in advance of conception, and state enforcement of the agreements at birth. A second report published one year later reached the opposite conclusion. As discussed in Part 5, the New York State Task Force on Life and the Law⁹⁶ recommended that commercial and paid arrangements be prohibited and that unpaid arrangements be unenforceable.

The Dunne Report proceeded from the assumption that "surrogate parenting is a logical extension of the constitutional right to procreate, and accordingly, a part of the constitutional right of privacy."⁹⁷ For this reason,

it did not prohibit the practice, yet in the interests of all the parties to the agreement, and in particular the child, it proposed regulation. Under the proposed terms, a prospective preconception arrangement would require judicial approval prior to an attempt to conceive. The purpose of the court proceeding would be to ensure that the parties are aware of their rights and obligations under the agreement and that they can give informed consent to the arrangement. Judicial approval would be required of any proposed fees to be paid to the carrying woman, her lawyer, and the broker. The criteria used to determine what constitutes "just and reasonable compensation" would be whether the fees and compensation are equitable, appropriate to the services rendered, and without coercive effect.

Approval of the arrangement would be provisional until the court received notice that the carrying woman had been medically evaluated to be free of sexually transmitted disease and that she had become pregnant with the semen of a commissioner who had been tested similarly. Upon receipt of this information, the court would make its approval final.

The effect of such approval would be that any child born to the carrying woman would be deemed the legitimate, natural child of the biological father and his wife. The commissioning woman would not need to adopt the child. If, however, blood tests revealed the commissioner to be genetically unrelated to the child, the statutory presumption of paternity could be rebutted. Although the carrying woman would be the sole decision maker concerning her pregnancy, once the child was born she would be required to relinquish it. Because the commissioners would be the legal parents, they would be required to support it from the time of conception and after birth.

Because of the paucity of information regarding the effects of preconception arrangements, the Dunne Report recommended that only couples in which the woman is medically certified as infertile be eligible to become commissioners.

Although the Dunne Report recognized that the carrying woman was at physical and psychological risk by the arrangement,⁹⁸ it nevertheless focussed on the "indications" of the commissioners and the fact that "for some couples, a surrogate mother provides the only means to have a child genetically related to one of them."⁹⁹ By thus focussing on demand and taking insufficient account of the harms and potential harms caused to the carrying woman, and taking no account whatsoever of the potential harms to the woman's other children, her husband, and parents, the Dunne Report did not fully consider the effects of the practice. It recommended to the New York State Senate that legislation be enacted to regulate preconception arrangements in such a way as to force women to give up their children conceived under an agreement.

By contrast, and as discussed in Part 5, the New York State Task Force, convened by State Governor Cuomo in March 1985, viewed the arrangements not as a technology but as a social arrangement "to enable one woman to produce a child for a man and, if he is married, for his

wife."¹⁰⁰ Because the agreements involved social decisions that potentially placed the rights of individuals in direct conflict, the right to enter into and to enforce a preconception arrangement was not considered to be protected by the constitutional right of privacy. The New York State Task Force recommended that public policy should discourage preconception arrangements by declaring them void and unenforceable and by making illegal the payment of fees to carrying women and the activity of brokers.

Under its proposals, unpaid arrangements would be governed by the state's adoption laws, which permit the payment of reasonable expenses associated with pregnancy and childbirth to a mother who relinquishes her child.¹⁰¹ Such payments require judicial approval. Should a carrying woman decide not to relinquish the child, however, she would not be compelled to do so except if, "based on clear and convincing evidence," a court decides the best interests of the child would be served by an award of custody to the commissioners.¹⁰² Support obligations and visitation rights would be awarded by the court under existing law.

The New York State Task Force was concerned with the social and moral issues to which the practice of preconception arrangements give rise. These issues touch on five central concerns: (1) individual access and social responsibility in the face of new reproductive technologies; (2) the interests of the children; (3) the impact of the practice on family life and relationships; (4) attitudes about reproduction and women; and (5) application of the informed consent doctrine.¹⁰³ This broad range of concern caused the Task Force to examine preconception arrangements in a wide social context and to recommend against social and legal endorsement of the practice.

California Proposal

In November 1990, the Joint Legislative Committee on Surrogate Parenting delivered to the California legislature its report entitled *Commercial and Noncommercial Surrogate Parenting*.¹⁰⁴ The committee was created in September 1988 and appointed an advisory panel of experts in August 1989. The majority of the 18-member advisory panel concluded that voluntary, unpaid preconception arrangements should be allowed and governed under existing adoption law in California. Both paid and commercial arrangements would be prohibited as would be the operation of brokers' agencies and advertising to place a child for adoption without a licence. Preconception arrangements would be void and unenforceable. The father of a child born pursuant to such an arrangement would be the person who donated the semen; the mother would be the birth mother irrespective of the origin of the ovum from which the child originated.

The advisory panel majority was motivated by concern about the commercial nature of preconception arrangements in California and the presupposition of the practice that children are property, commissioned for the benefit of adults. While the majority recognized the needs of infertile couples, it determined their needs ought not to take precedence over the

best interests of the children, which lie in not being the subject of paid transactions commercially brokered. For these reasons, the majority would criminalize not the practice of preconception arrangements but the respects in which it involves the exchange of money.¹⁰⁵

Canada

To date, only one Canadian jurisdiction has enacted legislation regarding preconception agreements. (Quebec has passed legislation that would render the agreements void.¹⁰⁶) Moreover, there have not been any official reports of preconception agreements that have been the subject of litigation. Yet, as has been described above,¹⁰⁷ Canadians do participate in the practice of making preconception agreements.

The Ontario Law Reform Commission Report, 1985

At the time of this writing,¹⁰⁸ there has been only one official proposal in Canada for the reform of the law in relation to preconception agreements: the 1985 OLRC's *Report on Human Artificial Reproduction and Related Matters*,¹⁰⁹ which has been discussed above in Part 4¹¹⁰ and is analyzed more fully in Appendix 2.¹¹¹ That report is unlike most other reports in common law jurisdictions in that it endorses the practice of preconception agreements and proposes the establishment of a regulatory scheme to govern the practice. Under the OLRC's proposals, the prospective participants would be required to appear before a family court judge who would question the participants and make a decision as to whether they could proceed with their proposed arrangement. If the judge approved their agreement and the payment to the carrying woman, the agreement would be, at the instance of the commissioners, specifically enforceable so that the commissioners could forceably remove the baby from its mother at birth. No action has been taken by the Ontario government to implement the recommendations of this report.

Conclusion

This part has examined the law relating to preconception agreements in four nations: the United Kingdom, Australia, the United States, and Canada. By analyzing legislation and proposals for reform in each of those countries, the section demonstrated that the subject of preconception agreements has engaged the attention of law makers and law reformers since the beginning of the 1980s and has resulted in a range of actual and proposed law. Whereas most legislatures and law reform proposals in the United Kingdom, Australia, and the United States have opposed the practice and enacted or recommended prohibitory legislation, the only official consideration of the issue in Canada to date endorsed preconception arrangements and recommended the establishment of a legislative scheme that would, among other things, require babies born pursuant to approved agreements to be taken, forcibly if necessary, from their mothers.

Part 7. The Permissibility of the Proposal Under International Law

In enacting legislation to ban paid and commercial preconception arrangements and to state that in the event of a custody dispute the infant should, *prima facie*, remain with its mother, a provincial government would be acting in accordance with international human rights instruments to which Canada has bound itself. Although some suggest that international law might grant Canadians a broad right to procreate, which encompasses the liberty to make preconception arrangements free from state interference,¹ the existence of this right cannot be substantiated. In fact, international law requires state parties to promote the best interests of children, which entails that children should not (in general) be separated from their parents or become the subject of commerce or exploitation.

International Declarations of Human Rights

An international human rights declaration merely announces the existence of human rights. It has no legal force. Nevertheless, it is an expression of government aspirations and, in the context of interpreting international treaties, can be of use in resolving uncertainties as to the meaning of a particular treaty. The international human rights declarations to which Canada is a signatory are, therefore, valuable statements of the principles upon which Canada has agreed to act.

Universal Declaration of Human Rights, 1948

Canada is a founding member of the United Nations, whose General Assembly adopted the Universal Declaration of Human Rights² on 10 December 1948.³ The declaration's purpose was to promote respect for the rights and freedoms that it enunciated and "by progressive measures, national and international, to secure their universal and effective recognition and observance."⁴ The declaration consists of a preamble and 30 articles setting forth the basic human rights and fundamental freedoms to which all men and women are entitled without discrimination.

Article 16 states,

- (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family ...
- (3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.⁵

Although the declaration recognizes the centrality of the family in society and seeks to protect the freedom of people to found a family, it appears to speak of protection from interference in natural reproduction. It does not require member states to offer citizens infertility services using third parties to found families when they are unable to do so themselves.

United Nations Declaration of the Rights of the Child, 1959

A second UN declaration asserts the existence of the rights of children. The UN General Assembly unanimously proclaimed the Declaration of the Rights of the Child⁶ on 20 November 1959⁷ "to the end that [the child] may have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth."⁸ The Assembly called upon "parents, upon men and women as individuals, and upon voluntary organizations, local authorities and national Governments to recognize these rights and strive for their observance by legislative and other measures."⁹

The Declaration of the Rights of the Child, to which Canada is a signatory, contains the following principles:

Principle 2

The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration...

Principle 6

The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother...

Principle 9

The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.¹⁰

The practice of preconception arrangements arguably violates Principle 2 in not treating the best interests of the child as a paramount consideration. Preconception arrangements clearly are contrary to Principle 6 in intending to separate children from their birth mothers.¹¹ Likewise, the practice violates Principle 9; by paying for the transfer of custody of a child, commercial and paid preconception arrangements constitute traffic in children.

The UN General Assembly's Declaration of the Rights of the Child is of moral force. As a member of the United Nations, Canada and its provinces would be acting in accordance with this declaration by passing legislation to protect children from social practices that might threaten their health or well-being or exploit them.

International Human Rights Treaties

Canada entered into a binding international legal obligation to promote human rights on 19 May 1976, when it ratified three UN human rights

conventions: the International Covenant on Economic, Social and Cultural Rights (ESC Covenant),¹² the International Covenant on Civil and Political Rights (Civil and Political Covenant),¹³ and the Optional Protocol to the International Covenant on Civil and Political Rights (Optional Protocol).¹⁴ The Optional Protocol is significant because by signing it, Canada gave its citizens the ability to complain to the UN Human Rights Committee of alleged human rights violations committed in Canada. The obligations that Canada assumed by these treaties would also be honoured by the enactment of the proposed legislation prohibiting paid and commercial preconception arrangements.

International Covenant on Economic, Social and Cultural Rights

The preamble to the ESC Covenant states that the rights recognized by the covenant "derive from the inherent dignity of the human person."¹⁵

Article 2 provides:

1. Each State Party to the present Covenant undertakes to take steps ... with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The State Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.¹⁶

In Article 10, the State Parties to the Covenant recognize that

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children.

Article 15 enunciates rights possibly relevant to exclusively gestational preconception arrangements, which rely on scientific knowledge.

1. The State Parties to the present Covenant recognize the right of everyone ...
- (b) To enjoy the benefits of scientific progress and its applications...
3. The State Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.¹⁷

Taken together, these provisions might be used to argue that Canada has an international legal obligation "to protect the establishment of families, by legislation if possible and necessary, and to afford individuals access to such 'benefits of scientific progress and its applications' as artificial means of conception, or at least not to deny that access where it is available."¹⁸ Thus, if a woman is willing to enter a preconception agreement, and a couple are willing to hire her in a genetic-gestational or exclusively gestational arrangement, it could be argued that Canada may not restrict the parties' liberty.

Yet, such an argument is predicated on a narrow interpretation of the “service” that the prospective carrying woman would provide. By gestating and giving birth to a child, she establishes a family. The transfer of the child from her to the commissioners founders their family at the expense of disrupting her own at a time when the ESC Covenant would specifically require that she be specially protected. Paragraph 2 of Article 10 provides,

2. Special protection should be accorded to mothers during a reasonable period before and after childbirth.¹⁹

Further, the subject matter of the transfer is a child who, under the ESC Covenant, may not be the subject of economic or social exploitation:

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation.²⁰

Further, it will be recalled that the preamble to the ESC Covenant acknowledged that the rights it recognizes derive from the inherent dignity of the human person. Arguably, the right to found a family must be predicated on an understanding of human dignity that acknowledges the unique relationship of mother and child.

Given these provisions, it would be difficult to base an argument on the ESC Covenant that commissioning couples have a right to found their families by entering into and enforcing preconception agreements requiring women to surrender the children to which they have given birth.

International Covenant on Civil and Political Rights

There is a second international covenant that might be used by proponents of the practice. The Civil and Political Covenant grants the rights it recognizes to all persons.

Article 2 states,

1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.²¹

Article 17 states,

1. No one shall be subjected to arbitrary or unlawful interference with his privacy [or] family ...²²

Article 23 states,

1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.²³

Again, it might be argued that commissioners have a right, based on these provisions, to use preconception arrangements to fulfil their desire to found a family. Yet such an argument must address why that right should be

granted to commissioners by means that break up another's family. Moreover, like the ESC Covenant, the Civil and Political Covenant states in its preamble that the rights it recognizes are predicated on the inherent dignity of the human person. Further, insofar as a preconception agreement is held to create a legal obligation from which carrying women are not entitled to escape, it is akin to servitude, which is forbidden by Article 8 of the Civil and Political Covenant:

1. No one shall be held in slavery; slavery and the slave-trade in all their forms shall be prohibited.
2. No one shall be held in servitude.²⁴

Insofar as home studies of commissioners are not part of a regime to govern preconception arrangements, children might be transferred into a home that will not serve their best interests. By thus treating commissioned children differently than adopted children, the practice might be in contravention of Article 24:

1. Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.²⁵

Optional Protocol on Civil and Political Rights

The Optional Protocol would grant Canadians who had exhausted their domestic remedies the right to complain to the UN Human Rights Committee of a breach by Canada of its international obligations.²⁶ For the foregoing reasons, however, the complainant would probably not be successful in arguing that the UN Human Rights Conventions, to which Canada is a signatory, prevent Canadian governments from passing legislation prohibiting commercial and paid preconception arrangements.

Thus, international law grants adult Canadians no right enforceable against the state to participate in a commercial or paid preconception arrangement. On the contrary, international law puts the state under a positive obligation to protect children. Under the UN Convention on the Rights of the Child,²⁷ which it ratified in December 1991, Canada has assumed duties toward children, the fulfilment of which prevents legal endorsement of preconception arrangements.

United Nations Convention on the Rights of the Child

The UN Convention on the Rights of the Child arguably prohibits the enactment in Canada of legislation endorsing the practice of preconception arrangements because such arrangements contemplate *ab initio* that:

1. the child will be separated from at least one of its parents — its mother;
2. the child will not usually be permitted to come to know its mother;

3. the child will usually be exchanged for money, sometimes across borders; and
4. the arrangement will serve primarily the best interests of the adults, with little or no regard for the best interests of the child.

These aspects of preconception arrangements are contrary to the rights of the child expressed in the Convention. Were Canada or its provinces to give legal effect to the practice of preconception arrangements, the governments would thereby prevent themselves from honouring their obligations under the Convention, which requires state parties *inter alia* to:

1. ensure that a child not "be separated from his or her parents against their will" except when separation is lawfully determined to be necessary in the child's best interests (Article 9(1));
2. grant every child "the right to know and be cared for by his or her parents" (Article 7(1));
3. respect "the right of the child who is separated from one or both of its parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests" (Article 9(3));
4. protect the child against all "forms of exploitation prejudicial to any aspect of the child's welfare" (Article 36);
5. take measures to combat the illicit transfer and non-return of children abroad (Article 11(1));
6. use their best efforts to ensure recognition of the principle that "both parents have common responsibilities for the upbringing and development of the child," and that "the best interests of the child will be their basic concern" (Article 18(1)); and
7. ensure that the system of adoption is governed by the "paramount consideration" of the best interests of the child (Article 21(1)).

Conclusion

International law does not recognize a right of adults to participate in preconception arrangements but, on the contrary, imposes a duty on the state to protect children. States impair their ability to fulfil this international legal duty by endorsing the practice of preconception arrangements.

Part 8. The Canadian Charter of Rights and Freedoms and the Regulation of Preconception Arrangements

Introduction

Having considered Canada's international legal obligations with respect to preconception arrangements, we now consider whether there exists a right to participate in preconception arrangements under the *Canadian Charter of Rights and Freedoms*.¹ We examine the likely effect of the Charter on government attempts to prohibit commercial and paid preconception agreements.²

This Charter analysis begins by considering briefly its applicability and then examining whether a right to procreate is entailed in a right to liberty or security of the person enunciated in Sec. 7 of the Charter, and whether such a right would include a right to enter into and enforce a preconception arrangement. After an examination of Sec. 15 to discuss equality rights, we consider whether a statute banning advertising would violate the right to freedom of expression under Sec. 2(b) and, finally, whether the proposed legislation would be saved by Sec. 1.

Application of the Charter

The Charter applies only to legislative regulation or other government intervention.³ It may be invoked against government if it seeks to restrict, by enacting laws or otherwise, a right guaranteed to the individual by the Charter. The Charter does not, however, apply to private law relations or to individual actions.⁴ Private commercial contracts are not subject to Charter scrutiny.⁵ Therefore, a participant in a preconception agreement or a person wishing so to participate could not invoke the Charter to complain of the activities of, for example, the broker or the other participants. The individual could, however, complain if the government restricted the exercise of a protected right associated with participation in a preconception arrangement. The proposed statutory regime, by making illegal commercial and paid agreements and advertising therefor, might violate Sec. 7, Sec. 15, or Sec. 2(b) of the Charter.

Section 7

Introduction

Section 7 states, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

To establish a breach of Sec. 7, the plaintiff must show, first, that his or her right to life, liberty, or security of the person has been violated, and then that this violation was not in accordance with the principles of fundamental justice.⁶ Would government interference with a person's freedom to enter into, to enforce, or to encourage a paid preconception arrangement constitute the deprivation of the right to life, liberty, or security of the person?

The answer to this question is not known. Although the Supreme Court of Canada has acknowledged that the concepts of the Sec. 7 rights "are capable of a broad range of meaning,"⁷ and that "it is incumbent upon the court to give meaning to each of the elements, life, liberty and security of the person, which make up the 'right' contained in s. 7,"⁸ the Court has not done so with precision.

We can be certain that state interference with participation in a preconception agreement does not constitute a deprivation of the right to life because such interference does not threaten or endanger life. Does it, however, violate the right to liberty or security of the person?

"Liberty" Under Section 7

Although the right to liberty has not been clearly delineated, it has some manifest minimum content. It includes deprivation of physical liberty such as imprisonment.⁹ Beyond this, the Supreme Court is not agreed as to the boundaries of the right. Some judges have discussed the possible breadth of the right but have not found it necessary to decide the issue. Other justices have attempted to describe the extent of the right with radically different results: whereas, for example, Madame Justice Wilson gives "liberty" an expansive meaning, Mr. Justice Lamer would restrict it to the context of the judicial system only.

In *Jones*,¹⁰ Wilson J. held that the right to liberty protects the right of parents to determine the education of their children in accordance with their own consciences. She found that "liberty" in the Canadian Constitution includes "the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his character, to make his own choices for good or ill, to be non-conformist, idiosyncratic and even eccentric."¹¹

Madame Justice Wilson further elaborated her expansive conception of the term "liberty" in *Morgentaler*,¹² where she decided that it prevents the state from interfering with a woman's decision to terminate her pregnancy. She grounded "liberty" in human dignity, which she said the Charter is designed to protect:

The basic theory underlying the Charter [is] that the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.¹³

Madame Justice Wilson stated that an aspect of the respect for human dignity on which the Charter is founded "is the right to make fundamental personal decisions without interference from the state."¹⁴ According to her, "liberty" in a free and democratic society "does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them."¹⁵ She held, therefore, that the right to liberty protects a woman's right to decide for herself whether to terminate her pregnancy.

Given the breadth of the scope she has given to liberty in *Jones* and *Morgentaler*, it might be argued that Wilson J. would include, within the

right, the freedom to participate in preconception arrangements. Yet, though her reading would almost certainly entitle a woman to enter such an arrangement, Wilson J. would probably grant that a right to liberty grounded in human dignity entails that a woman should be free to decide whether to terminate her relationship with her child only once the child is born. In other words, Wilson J. might agree with provincial law regarding adoption that the relevant time to exercise one's liberty in choosing to relinquish a child is some days after giving birth. Secondly, Wilson J. might also find that liberty grounded in human dignity does not include the right to offer women financial inducements to part with their children.

Madame Justice Wilson's broad interpretation of the right to liberty is not shared. Another member of the Supreme Court who has also adjudicated on the issue has held that "liberty" is to be understood in much narrower terms. In the *Prostitution Reference*,¹⁶ Mr. Justice Lamer stated that Sec. 7 must be read in conjunction with Secs. 8-14 of the Charter, which also fall under the heading "Legal Rights" and have to do with the citizen's relationship to the judicial system. In his view, legal rights are different from the rights guaranteed by other sections of the Charter.¹⁷

According to Lamer J., Sec. 7 is concerned with restrictions on liberty and security of the person that occur as a result of an individual's interaction with the justice system and its administration. He held that Sec. 7 protects individuals from the state when the state invokes the judiciary to restrict a person's physical liberty; restricts their security of the person by interfering with, or removing from them, control over their physical or mental integrity; and uses the threat of punishment in cases of non-compliance. On Mr. Justice Lamer's more narrow reading of Sec. 7, it appears that the freedom to participate in preconception agreements would not be protected.

To summarize, the right to liberty in Sec. 7 has not been clearly defined by the Supreme Court. Madame Justice Wilson's notion of "liberty" is broad enough to protect the freedom of parties to enter into unpaid, non-commercial preconception agreements but probably not to enforce them. No other judge has concurred with her in this broad interpretation of the right. It appears, therefore, the majority would probably not find that the right to liberty guaranteed in Sec. 7 prevents state interference in preconception agreements.

"Security of the Person" Under Section 7

Would the state be prohibited from interfering in such agreements on the grounds that to do so violates Sec. 7's guarantee of security of the person? Again, the definition of "security of the person" has not been clearly articulated.

Madame Justice Wilson has said in *Re Singh* that the phrase "security of the person" is capable of broad meaning.¹⁸ Yet, there she decided only that "security of the person" "must encompass freedom from the threat of physical punishment or suffering as well as freedom from such punishment itself."¹⁹

Similarly, Chief Justice Dickson gave it a narrow meaning in *Morgentaler* when he held that it entails freedom from "state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal context."²⁰ On this reading, a commissioning man who was criminally prohibited from attempting to hire a woman to conceive, bear, and surrender a child to which he was genetically related might argue that the prohibition constitutes serious state-imposed psychological stress in the criminal context. Whether "security of the person" could be used in this way is not clear because the Chief Justice stated he would not explore the broadest possible implications of Sec. 7, such as whether it entails a right to control one's own life and promote one's individual autonomy and whether it protects interests central to personal autonomy such as the right to privacy and issues unrelated to criminal justice.

In the same case, Mr. Justice Beetz also considered the meaning of "security of the person," but he, too, was cautious in his approach. He stated that it included a woman's freedom from a criminal law that would preclude her from obtaining effective and timely medical treatment.²¹ Although it might be argued that, from the perspective of the commissioning woman, a preconception arrangement is medical treatment, we have seen in Part 4²² that this argument is without foundation.

Madame Justice Wilson's decision in *Morgentaler* defines "security of the person" sufficiently broadly to encompass participation in a preconception arrangement but, again, would probably grant the woman the right to decide whether to relinquish only at birth. In *Morgentaler*, she stated that "security of the person" protects both the physical and psychological integrity of the individual and that this, in turn, requires that a woman's capacity to reproduce be subject to her own control. To interfere with her decision whether to exercise her reproductive capacity by limiting the availability of abortion is a direct interference with her physical "person" as well, for then she is treated not as an end in herself, which is compatible with respect for her human dignity, but rather as a means.²³ Similarly, to the extent that a preconception arrangement treats a woman as a means of reproduction and denies her decision-making power over her child once she has given birth, Wilson J. might hold that the enforcement of a preconception arrangement would violate a woman's right to "security of the person."

Thus, it appears that the Sec. 7 guarantee of the right to liberty and security of the person protects individuals at least from deprivations of physical liberty and physical or psychological integrity. It could be argued they would permit legislation prohibiting persons from offering women financial inducements to part with their children and preserving a woman's right to choose to relinquish her child until after she gives birth.

Fundamental Justice

The principles of fundamental justice are vague. It appears they concern both procedure and substance²⁴ and contain, at a minimum, the notion of procedural fairness: "the tribunal which adjudicates upon [an

individual's] rights must act fairly, in good faith, without bias and in a judicial temper, and must give to [the individual] the opportunity adequately to state his case."²⁵

The substantive aspects of the principles of fundamental justice are "to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system."²⁶ To avoid passing judgment on the wisdom of legislation, the Court has recognized the competing tensions that legislatures must reconcile when creating public policy and will, where possible, pay deference to their decisions.²⁷

If a Canadian legislature banned the practice of commercial and paid preconception agreements, it appears that the substantive principles of fundamental justice would require that its decision not be arbitrary.²⁸ Beyond that, the Court would consider whether the legislation accords with "a system for the administration of justice which is founded upon a belief in 'the dignity and worth of the human person'... and on 'the rule of law.'"²⁹ Future growth of the substantive aspect of the principles of fundamental justice will "be based on historical roots." Ultimately the decision will rest on "an analysis of the nature, sources, rationale and essential role of [the principle of fundamental justice] within the judicial process and in our legal system, as it evolves."³⁰ Participation in a preconception arrangement has not been given special protection by our legal system. It is unlikely, therefore, that legislation banning the practice would violate the principles of fundamental justice, provided it does so on principled and not arbitrary grounds.

Section 7 as Applied in Lower Court Family Law Cases

Moreover, in the context of preconception arrangements, consideration for the best interests of the child might be viewed as more important than adults' rights to liberty or security of the person. When lower courts have considered the scope of parental rights under Sec. 7, the issue has usually been a matter related to the state having apprehended a child for its own protection. In such circumstances, the courts have not been tolerant of arguments that parents have broad constitutional rights to liberty and security of the person with respect to their children; they have held that children's rights to liberty and security of the person outweigh any putative parental right.³¹ In fact, the Ontario Court of Appeal refused to hear argument on Sec. 7 in a case where a mother pleaded that the denial of access to her children and the termination of her parental rights by adoption violated her right to life, liberty, and security of the person.³² The two children had been apprehended by the Catholic Children's Aid Society for their protection. Mr. Justice Tarnopolsky, speaking for the court, stated,

I do not see how a termination of access to a Crown ward because of adoption deprives the birth parent of any one of life, liberty, or security of the person. Clearly, such termination is not a deprivation of life. I do not see either how it can constitute a deprivation of liberty or security of

the person. No one has a right to go everywhere ... Barring a person from having access to a particular person is not a confinement ... There is no deprivation of life or liberty or security of the birth parents in having access to their natural children terminated with a view to having those children adopted by new parents.³³

The lower court decisions in Canada that have pronounced on the subject of parental rights in Sec. 7 have done so in the context of a child in need of protection. Because a potential preconception arrangement case would be unlikely to involve a child in need of protection, arguably these cases are not apposite. Nevertheless, they are indicative of judicial determination to give the interests of children more weight than those of the parents. The same principle will almost certainly apply in a case of disputed custody or access to a commissioned child.

Section 15

The next issue for consideration is whether the proposal that would prohibit commercial and paid preconception arrangements, render all others unenforceable, and specifically grant a woman custody after giving birth in the event of a dispute is a proposal that would violate Sec. 15. An argument might be raised that such provisions discriminate against persons with a disability (the infertile) and persons who are homosexual.

Section 15 provides:

- (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
- (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The starting point for Sec. 15 analysis is the decision of Mr. Justice McIntyre in *Law Society of British Columbia v. Andrews*.³⁴ There, he described the purpose of Sec. 15 and the procedure for determining whether it has been infringed.

The purpose of Sec. 15 is not to guarantee that the law treats people equally, but to ensure it treats people as equals.³⁵ In protecting against discrimination based on prejudice and stereotyped beliefs and assumptions, Sec. 15 attempts to grant as nearly as possible

an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another. In other words, the admittedly unattainable ideal should be that a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.³⁶

To prove that a law violates Sec. 15, the plaintiff must demonstrate two things: first, that an equality right has been denied; and second, that the impact of the law is discriminatory.

To prove the first, the plaintiff must show that he or she has been denied the right to equality before the law, equality under the law, the equal protection of the law, or the equal benefit of the law. The exact meaning of each of these specific rights has not yet been defined by the Supreme Court. However, the purpose of "equality before the law" has been defined by Madame Justice Wilson in *R. v. Turpin*:

The guarantee of equality before the law is designed to advance the value that all persons be subject to the equal demands and burdens of the law and not suffer any greater disability in the substance and application of the law than others.³⁷

The four equality rights together ensure both procedural and substantive equality and equality in the result or effect of the law.

In addition to showing that the law violates one of these four rights, the plaintiff must demonstrate the law does so in a discriminatory manner. The Supreme Court has adopted the definition of "discrimination" articulated by McIntyre J. in *Andrews*:

[D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or groups not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.³⁸

It is not enough for a plaintiff to show that the impugned law makes a distinction. The law must impose a burden that has a demonstrably unequal impact on an enumerated or analogous group. According to Mr. Justice McIntyre, such a group is one that can be described as "a discrete and insular minority"³⁹ that is the subject of "socially destructive and historically practised"⁴⁰ discrimination. According to Madame Justice Wilson in the same case, whether a group is entitled to Sec. 15 protection is determined by looking beyond the enumerated grounds to the context of the law that is subject to challenge and to the context of the place of the group in the entire social, political, and legal fabric of our society. Thus, non-citizens in *Andrews* were a group afforded protection by Sec. 15 because they are "a group lacking in political power and [are] vulnerable to having their interests overlooked and their rights to equal concern and respect violated."⁴¹

From this analysis, it is clear that legislation that makes illegal the practice of preconception arrangements and that has an adverse impact on

an enumerated or analogous group would violate Sec. 15. On the other hand, legislation that has an unequal impact on a group that is not analogous to the enumerated groups in Sec. 15 would not violate equality rights.

Commissioners might challenge the proposed law on the basis that it discriminates against them because of their disability, which is infertility or impaired fecundity. To determine whether they would succeed it is important to distinguish between commissioners. Usually the commissioning woman cannot conceive and carry a child to term, whereas the commissioning man is capable of fathering a child. Their situations are therefore relevantly different for the purpose of Sec. 15 analysis.

A commissioning woman would not be able to show that the impugned criminal law denied a right to equality in a discriminatory way. She might be able to demonstrate that the law had an unequal effect on her in that, whereas the law did not interfere with a fertile woman's decision to have children, it did interfere with hers and thus denied her equal benefit of the law.

But could she successfully take the second step and prove that the denial constituted discrimination on the basis of her disability? The Crown would argue that the law does not prevent her from having children, nature does. As David Lepofsky has written, "When a mental or physical disability renders it impossible for an individual to participate in an opportunity, there is no denial of equality of opportunity where that opportunity is unavailable to [the individual]."⁴² The commissioning woman might counter that in the case of exclusively gestational arrangements, she is capable of having a genetically related child, but the law denies her the freedom to avail herself of the technology and access to an exclusively gestational woman who would carry the embryo to term. The commissioning woman might also cite David Lepofsky to support her claim that the proposed law denies her equality on the basis of her handicap:

Inequality occurs and discrimination is imposed when handicapped persons are denied access to benefits, rights or responsibilities because of their handicap in situations where, in fact, their handicap does not itself impede the undertaking of the rights, responsibilities or benefits.⁴³

In effect, then, her argument would be that the combination of technology and the willingness of another woman to cooperate would enable her to have a child, but the law denies her this benefit because she is handicapped.

Such an argument would not succeed, for it is clear the law would deny her the benefit not because she is handicapped but rather because of the very premise of equality rights, which is that the fundamental human dignity of persons must be protected. A law prohibiting commercial and paid preconception arrangements would be predicated on the need to ensure the human dignity of prospective carrying women and their children.

To state that such a law has a discriminatory purpose and effect would be equivalent to saying that a law prohibiting the sale of kidneys discriminates against persons in need of kidneys. Although the law has an adverse impact on that group of persons, to the extent that the law results in a lower supply of kidneys, it cannot be said the law is discriminatory. The law does not discriminate on the basis of a disability but rather controls the means by which the disabled may alleviate the suffering caused by their disability.

Nor could the commissioning man, irrespective of whether he is married, successfully plead Sec. 15. If he is a member of a heterosexual couple, he is usually not the disabled party. The law does not prevent him from fathering a child with a woman who is not his wife or partner. A law that prohibits commercial and paid preconception arrangements does limit his freedom to do so, but this limitation cannot be described as discriminatory. On what basis could it be so described? Typically, would-be commissioning fathers are white, relatively well educated, affluent, able-bodied, heterosexual men between the ages of 30 and 60.⁴⁴ As such, they are not members of an enumerated or analogous group.

If, however, the commissioning man is not able-bodied in the sense that he is infertile, his argument of discrimination on the basis of disability would be met by the same response as that of the infertile commissioning woman's claim.

Could homosexual persons who wish to raise children successfully claim that the proposed criminal law has an adverse impact on them that is discriminatory? It appears the law would deny a homosexual man equal benefit in that it would have the effect of preventing him from participating in an agreement that might result in his raising his genetically related child. But could he argue that the law discriminates on the basis of sexual orientation?

It seems clear that homosexual persons are an analogous group for the purposes of Sec. 15. They have suffered a history of discrimination, remain relatively politically powerless, and are the subject of hatred and violence.⁴⁵ Nevertheless, it cannot be said that a law preventing commercial and paid preconception arrangements discriminates against them on the basis of sexual orientation. The purpose of the law would not be to prevent homosexuals from obtaining children to raise; its purpose would be to protect a vulnerable group, certain women and children, from exploitation and harm violating their human dignity. While acknowledging that the law would have an unequal impact on, for example, gay men whose sexual orientation precluded them from wishing to have sexual intercourse with a woman to conceive and raise a child with her, the law would be directed at protecting a more vulnerable group. It would not deny homosexual persons the freedom to raise children related or unrelated to them but it would, for reasons of justice and human dignity, limit that freedom. A law prohibiting commercial and paid preconception arrangements might have an effect on homosexual persons that would be unequal to that on

heterosexual fertile couples, but the law could not be described as a law that discriminates on the basis of sexual orientation.

It appears, therefore, that arguments by infertile or homosexual persons that the proposed legislation discriminates against them on the basis of their disability or sexual orientation contrary to Sec. 15 would be unsuccessful.

Section 2(b)

The next constitutional issue is whether a statute prohibiting advertising by brokers, commissioners, or prospective carrying women violates the Charter's guarantee of the right to freedom of expression. The answer is clearly yes.

Sec. 2(b) of the Charter states,

2. Everyone has the following fundamental freedoms: ...

- (b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication.

The proposed statute would prohibit the advertisement of a broker's willingness to bring commissioners together with carrying women, commissioners' desire to hire a carrying woman, and a carrying woman's wish to act as such. The method for determining whether these restrictions on freedom of expression would violate Sec. 2(b) has been set out by the Supreme Court in *Irwin Toy v. Quebec (A.G.)*⁴⁶ and consists of three questions.

The first question is whether the activity prohibited by the statute may properly be characterized as falling within "freedom of expression." The test is whether the activity has expressive content in that it conveys or attempts to convey a meaning.⁴⁷ Clearly, advertisements by brokers, commissioning couples, or carrying women of their willingness to participate in a preconception arrangement are activities that convey meanings. Although these meanings might be characterized as commercial rather than political, the right to freedom of expression is not confined to political expression but extends to commercial expression.

Commercial expression ... protects listeners as well as speakers [and] plays a significant role in enabling individuals to make informed economic choices, an important aspect of individual self-fulfilment and personal autonomy.⁴⁸

Thus, the commercial expression of brokers, commissioning couples, and carrying women that would be banned by the statute may properly be characterized as falling within "freedom of expression."

The second question is whether the expressive activity limited by the statute is excluded from Sec. 2(b) because it takes a prohibited form. An example of a prohibited form is violence or threats of violence.⁴⁹ Clearly, advertisements do not fall into this category of prohibited forms of expression.

The third question is whether the purpose or effect of the impugned statute would be to control or attempt to control the meanings that persons wish to convey. A statute banning advertisements concerning preconception arrangements would be a statute designed to restrict expression by singling out meanings that are not to be conveyed. In thus restricting the content of expression protected by Sec. 2(b), the statute would violate the Charter's guarantee of the right to freedom of expression.

Section 1

From the foregoing analysis, it seems that the proposed statute would probably not violate either Sec. 7 or Sec. 15, but it is clear that it would violate Sec. 2(b). The final question for consideration in this section is whether, despite any denial of a Charter right, the statute would be upheld by Sec. 1.

Section 1 provides,

The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

A plaintiff must first prove that a Charter right has been infringed. The party seeking to uphold the limitation (usually a government) must then prove on the balance of probabilities that the limitation is prescribed by law and is demonstrably justified.

To be upheld as a limit "prescribed by law," the law must not be arbitrary; it must be intelligible though it need not be absolutely precise.⁵⁰ As the majority stated in *Irwin Toy*,

Absolute precision in law exists rarely, if at all. The question is whether the legislature has provided an intelligible standard according to which the judiciary must do its work. The task of interpreting how that standard applies in particular instances might always be characterized as having a discretionary element, because the standard can never specify all the instances in which it applies.⁵¹

Once the government demonstrated that the statute was a "limit prescribed by law," it would then need to prove it was reasonable and demonstrably justified in a free and democratic society. The framework for determining whether this second requirement has been met was initially articulated by the Supreme Court in *Oakes*.⁵² The *Oakes* test requires that the party seeking to uphold the limit first show that the objective the limit is designed to serve is sufficiently important to justify overriding the right or rights it infringes, and second, that the means chosen are reasonable and demonstrably justified with respect to the objective sought.

Assuming that an *intra vires*, sufficiently important objective has been established, the means chosen to achieve the objective must pass the proportionality test set out by *Oakes*. The means must

- (a) be "rationally connected" to the objective and not be arbitrary, unfair or based on irrational considerations;

- (b) impair the right or freedom in question as "little as possible"; and
- (c) be such that their effects on the limitation of rights and freedoms are proportional to the objective.⁵³

Exactly how the *Oakes* test would be applied in the case of the proposed statutory regime is uncertain. It depends, to a large extent, on shifting judicial attitudes toward Charter interpretation.⁵⁴ Two cases are, however, of particular use in attempting to determine how a court would apply Sec. 1 to the proposed scheme.

In both *Edwards Books*⁵⁵ and *Irwin Toy*,⁵⁶ the Court demonstrated considerable deference to the legislature for the reason that, in each case, the government measures were designed to protect vulnerable groups. In *Edwards Books*, Dickson C.J. accepted the determination of Law Reform Commissioners that employees in the retail industry were economically vulnerable.

The concern, then, is mainly for low-skilled, non-union and poorly educated employees whose continued earnings are critical for family support, people who have the least mobility in terms of job alternatives and are least capable of expressing themselves to redress their grievances.⁵⁷

In considering whether the Ontario statute regulating Sunday closing was saved by Sec. 1, Dickson C.J. was particularly attentive to the legislature's concern for "vulnerable employees":

In interpreting and applying the Charter I believe that the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons.⁵⁸

In *Irwin Toy*, the Court again deferred to the legislature's determination of how to protect a vulnerable group — in this case children under 13 years of age. The impugned legislation prevented advertisements directed at such children because they are unable to identify the persuasive intent of advertising and are therefore particularly vulnerable to the techniques of seduction and manipulation abundant in advertising. Chief Justice Dickson again wrote that the Court should be careful of balancing means and ends in such a way as to favour the advantaged.

In matching means to ends and asking whether rights or freedoms are impaired as little as possible, a legislature mediating between the claims of competing groups will be forced to strike a balance without the benefit of absolute certainty concerning how that balance is best struck. Vulnerable groups will claim the need for protection by the government whereas other groups and individuals will assert that the government should not intrude ... as courts review the results of the legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of the legislature's representative function.⁵⁹

In other words, it is likely that a court considering the constitutionality of the proposed legislation would attend to the fact that it is directed to protect vulnerable groups: would-be carrying women and their children. In applying the *Oakes* test as modified by *Edwards Books* and *Irwin Toy*, it seems clear the proposed legislation, even if it violated Secs. 7, 15, and 2(b), would be constitutional. The legislation's limitation on the Charter rights would be reasonable and demonstrably justified in a free and democratic society. The objective of the legislation would be not to deny commissioners the right to procreate but rather to limit the means by which they might legitimately alleviate their suffering in order to protect primarily two vulnerable groups: prospective carrying women and their children. As *Edwards Books* and *Irwin Toy* acknowledge, a goal that protects vulnerable persons from economic inducement to act against their interests is sufficiently important to justify overriding the right or rights it infringes.

With respect to the means chosen, the legislature must demonstrate that there is a rational connection between the statute and the objective. Because most harms of the practice arise because of financial inducement to participate in them, a ban on paid and commercial arrangements and advertisements would constitute legislation directed at those situations most likely to give rise to harm.

The proposed legislation would impair Charter rights as little as possible because, while prohibiting payment and advertisements, it does not deny women the freedom to conceive a child and to relinquish it. The proposal would not give the commissioners *prima facie* rights to the child because it would declare the agreement void and it recognizes the imbalance of power between the commissioners and carrying women. Given the emotional and physical difficulty of gestating and giving birth and the probable desire of the carrying woman not to hurt the commissioners, it would be unfair to require her to take positive steps to keep her child. As in other aspects of family law, the onus ought to be on others to prove she is an unfit mother and therefore subject to having her child removed from her; or if she chooses to relinquish the child, the onus should be on her to take steps to surrender the child for adoption.

The means chosen by the legislature must be shown to be such that the effects on the limitation of rights and freedoms are proportional to the objective. Since the legislative goal would be to protect two vulnerable groups and the means chosen would be merely to extend existing family law (which already regulates custody agreements and adoption) to the analogous situation of preconception arrangements, the effects on the Charter rights in Secs. 7, 15, and 2(b) are proportional to the objective. Thus, despite the indeterminacy of Sec. 1 application, it appears it would save the proposed legislation even if it were thought to limit a right guaranteed by the Charter.

Conclusion

The foregoing analysis has demonstrated it is unlikely there exists a right guaranteed by the Charter that would prevent Canadian governments from legislating to make illegal commercial and paid preconception agreements, to render unenforceable all other such agreements, and to prohibit any advertisements for preconception arrangements.

Appendix 1. U.S. Privacy Cases and the Right to Procreate

The amendments to the U.S. Constitution constituting the Bill of Rights do not explicitly recognize either the right of individuals to procreate or the existence of related rights. Yet, a number of cases regarding procreative capacity, marriage, child-rearing, contraception, and abortion contain expansive dicta proclaiming rights in intimate matters derived from a basic right to liberty and privacy. These cases have been relied on by legal commentators such as John Robertson and by Mr. Justice Sorkow in the first instance decision in *Baby M*,¹ to establish the proposition that there is a right of married couples to procreative liberty, that is, to procreate "when, with whom, and by what means one chooses."² But this argument is not well founded because the holdings in the Supreme Court cases upon which it relies in fact protect rights much narrower than those claimed. The argument, therefore, is unlikely to be successful in a judicial proceeding in establishing a right to be free from government interference in preconception arrangements.

A right to procreative liberty was first proclaimed by the U.S. Supreme Court in the case of *Skinner v. Oklahoma*.³ There, the Court struck down an Oklahoma statute authorizing the sterilization of "habitual criminals." Mr. Justice Douglas said,

We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power, if exercised, to sterilize may have subtle, far-reaching and devastating effects ... There is no redemption for the individual whom the law touches ... He is forever deprived of a basic liberty.⁴

Despite the expansive language, it is important to note the Court presumed procreation would take place within the context of marriage. Further, the Court did not hold that sterilization, *per se*, violated the Bill of Rights. Rather, it struck down the statute because it violated the Equal Protection clause of the Fourteenth Amendment; the Oklahoma statute had authorized sterilization in an unequal way, sterilizing "habitual criminals" but not those who committed what we might today call "white collar crimes," *viz.*, violations of revenue acts and prohibitory laws, embezzlement, and political

offences. Thus, although the Court declared the existence of a basic liberty — the right to procreate — it assumed its exercise in marriage and suggested it might be permanently denied by sterilization provided the legislators did so in an equal way.

In addition to the right to be free from involuntary sterilization, the U.S. Supreme Court has recognized the right to marry. The Court has held that the state may not prevent persons from marrying on the grounds they are of different races,⁵ or to secure compliance with support obligations.⁶ In the latter decision, *Zablocki v. Redhail*, the Court affirmed that "the decision to marry [is] among the personal decisions protected by the [constitutional] right of privacy."⁷

Nevertheless, the freedom to marry is not unlimited in the United States. As the legitimate opportunity for procreation, marriage may be entered into but only under certain constraints. States may pass laws prohibiting consanguineous unions and bigamy, and may restrict marriage to persons who have consented and who are of a particular age and mental capacity, and of opposite sexes.⁸

In addition to the freedom to retain procreative potential and the liberty to marry within constitutionally protected limits, the Court has also recognized a right to rear children, which grants parents the power to make important decisions about the child's education. In 1922, the Court struck down a Nebraska criminal statute preventing the teaching of a language other than English to children not yet in grade nine. In *Meyer v. Nebraska*,⁹ Mr. Justice Reynolds stated that the due process clause of the Fourteenth Amendment protects the right of persons "to marry, establish a home and bring up children."¹⁰ In so holding, he situated the parental right to make educational decisions for their children in the context of marriage. A subsequent case, *Pierce v. Society of the Sisters*,¹¹ which used the due process clause of the Fourteenth Amendment to protect the parents' right to choose which school their children would attend, suggested that the right that parents and guardians have to direct the education of children is attendant upon their duty to carry out their responsibilities toward the children.¹²

Likewise, the U.S. Supreme Court has recognized that parents have a limited right to maintain relationships with their children. In *Stanley v. Illinois*,¹³ the Court held that an unwed father who had established a relationship with his children was entitled to a hearing to determine his fitness as a parent, before his children could be taken from him permanently. But where the father had not legitimized the child, either by marrying the mother or by recognizing the children as his own, and the child was with its mother and her husband, the state was entitled to recognize the new family unit by terminating the father's rights and allowing the husband to adopt the child provided that was in the best interests of the child.¹⁴ These two cases establish that a father's rights to his children borne by a woman who is not his wife are not absolute but contingent on the best interests of the child.

Thus, although the U.S. Supreme Court has recognized a liberty interest that prevents the state from interfering in certain matters related to procreation, marriage, child-rearing, and retention of parental rights, it has done so within a particular context and without suggesting that the liberty might never be restricted in a manner contrary to an individual's interests. As we have seen, the Court has protected reproductive capacity by preventing an operation that would forever eliminate the ability to procreate,¹⁵ and it struck down legislation that prevented marriage on the grounds of race¹⁶ and indigency.¹⁷ Yet the Court would recognize a legitimate state interest in preventing consanguineous¹⁸ or homosexual unions,¹⁹ or the marriages of persons unable to consent for reasons of age or mental infirmity.²⁰ The Court acknowledged parents' freedom to direct their child's education but assumed the exercise of this freedom would be within marriage and for the benefit of the child.²¹ Similarly, a father's right to prevent the termination of his parental rights was contingent upon whether he married the mother of his child and what was in the best interests of the child.²² Thus, it is clear that the test of reproductive freedom, which these cases use, is not simply the interests of adults; the Court has used broader criteria, including the best interests of the child.

Proponents of the argument of procreative liberty rely also on the contraception and abortion cases to substantiate their claim, but these cases do not establish that a right to reproduce is unlimited and is based exclusively on adults' interests.

When the Supreme Court struck down the criminal statute preventing the sale or distribution of contraceptives to married persons,²³ the Court affirmed the existence of a marital right to privacy protected by the penumbra of the Bill of Rights:

The entire fabric of the Constitution and the purposes that clearly underlie its specific guarantees demonstrate that the rights to marital privacy and to marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected.²⁴

This decision was reinterpreted in a subsequent case, *Eisenstadt v. Baird*,²⁵ by expanding the protection to unmarried persons. In rendering the judgment, Mr. Justice Brennan uttered dicta that constitute the strongest evidence of a right to procreate without government interference and in a manner that might entail participation in a preconception arrangement. Mr. Justice Brennan said,

If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.²⁶

Although these words have been seized upon in support of the argument that the right to privacy entails the right to participate in non-coital reproduction,²⁷ it is important to recall the exact nature of the holding. The case stands for the proposition that the right to marital privacy, which

prevents state interference in a married couple's access to contraception, extends also to unmarried persons by virtue of the Equal Protection Clause of the Fourteenth Amendment. Not only is the case silent about whether the privacy right thus expanded protects a couple's freedom to reproduce outside a monogamous relationship, it explicitly allows for limits when the governmental restriction of the privacy right is warranted.²⁸

Likewise, the famous *Roe v. Wade* case proclaimed a privacy right that was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."²⁹ But, again, the Court specifically stated that the right was limited after the first trimester, when the interests of the fetus also had to be taken into account.³⁰

Thus, from the correct premise that the Supreme Court has, by these reproductive privacy cases, established a right residing at least in married couples to have children by sexual intercourse without interference from the state, some legal commentators³¹ have erroneously stated that there exists a right at least of married couples to have children by means other than through sexual intercourse with each other. The most persistent in this view is John Robertson, who has repeatedly written that it follows from the right to reproduce coitally that there is a right to reproduce non-coitally and collaboratively. He writes,

Two points that have great significance for the new reproductive technologies follow from constitutional acceptance of a married couple's right to reproduce coitally. First is the right of the married couple to reproduce noncoitally as well, through such means as artificial insemination with the husband's sperm or through extracorporeal fertilization — the IVF process. Second is the right to reproduce noncoitally with the assistance of donors and surrogates.³²

This line of reasoning was seized upon by Mr. Justice Sorkow in the first instance decision in *Baby M.*³³ There he quoted John Robertson at length:

[M]arried persons ... have a right to bear, beget, birth, and parent children by natural coital means using such technological aids ... as are medically available. It should follow that married persons also have a right to engage in noncoital, collaborative reproduction, at least where natural reproduction is not possible.³⁴

Yet, as we have seen, Robertson's reasoning that the right to privacy in procreation entails a right to participate in preconception arrangements is not substantiated by the case law. The argument inaccurately suggests that individuals' reproductive rights are unlimited. It incorrectly assumes that the conditions for procreation that exist in marriage and are constitutionally protected continue to exist when the couple go beyond each other to a third party for procreation. Yet, the privacy right protects procreative potential, not opportunity.³⁵ As we have seen, U.S. constitutional law prevents the state from limiting potential by sterilization, but allows it to restrict opportunity by statutes that prohibit fornication and

adultery and that set forth the requirements of persons to be married. In legislating on the matter of preconception arrangements, the state would be legislating about opportunity because the arrangements contemplate the creation and gestation of a child by two persons who are not married to each other and are usually married to other persons. Moreover, the right to privacy entails intimacy. Commercial and paid preconception arrangements are seldom characterized by intimacy. The process usually entails the decision of more than two persons (some of whom might never have met) to have a child, public advertisements, and the involvement of doctors and, in commercial arrangements, of brokers. Thus, contrary to Robertson, the reproductive privacy right is limited in ways that would probably exclude the right to commission a child.

A more fundamental criticism of the right to "procreative liberty" is that the U.S. Constitution is based on the dignity of human beings and arguably cannot be used to justify a practice that has serious actual and potentially harmful effects for a wide range of persons. Therefore, it is unlikely that, in the United States, the right of reproductive privacy is broad enough to protect participation in preconception arrangements.

Appendix 2. Analysis of the Ontario Law Reform Commission's Arguments Regarding Preconception Arrangements

On 5 November 1982, the Attorney General of Ontario, Mr. Roy McMurtry, requested the OLRC to inquire into and consider the legal issues relating to the practice of human artificial insemination, including "surrogate mothering" and transplantation of fertilized ova to a third party, and to report on the range of alternatives for resolution of any legal issues that might be identified. The OLRC delivered its two-volume report in 1985.¹

The members of the OLRC were five men,² each a lawyer, who were advised by the consultant to the project, Bernard M. Dickens, Professor of Law, University of Toronto. The OLRC (with one dissentient)³ endorsed the practice of preconception agreements and recommended the establishment of a regulatory scheme to govern it.

In discussing the issue, the OLRC examined approaches to preconception agreements recommended and adopted in other jurisdictions, in particular, the United Kingdom, the United States, and Australia. It noted that in some reports, opposition to the practice was expressed without supporting reasoning, "as if the impropriety of this reproductive alternative were self-evident."⁴ The OLRC then considered and commented on the arguments actually articulated in those reports. The first set of arguments opposed to the practice related to payment of the carrying woman.

It has been argued that it is an affront to human dignity and integrity for a woman, in effect, to rent her uterine capacity to another ... that such a practice invites exploitation of disadvantaged women by the more economically powerful. If widespread, the practice could lead to the establishment of a veritable "class" of child-bearing women. A corollary of this argument is that surrogate motherhood degrades the child for whose conception and transfer money is exchanged, by treating him or her like a commodity.⁵

The majority responded that these arguments focus exclusively on the profit-making aspects of preconception agreements. The majority claimed that, "were such aspects controlled, these arguments would be undermined considerably."⁶ In their recommendations, the majority advises the government to ensure that "all payments relating to a surrogate motherhood agreement must receive the prior approval of the court."⁷ Without explaining how, the majority said that "this prophylactic measure will reveal any financial exploitation of a surrogate mother by the prospective social parents."⁸ Indeed, Allan Leal in dissenting from the majority was specifically concerned about the ability of a regulatory scheme to prevent exploitation. He wrote,

I am not sanguine about the enforceability of these strictures in a context where both parties to a surrogacy agreement are prepared to have funds change hands outside the agreement. Unhappily, collusive agreements are neither novel nor infrequent where the desires of the parties coincide in the pursuit of an unlawful purpose.⁹

A second set of arguments advanced in law reform reports opposed to the practice was that the practice of preconception arrangements is immoral because it enables one person to serve as a means to the ends of another. The OLRC majority, however, argued that,

as an absolute precept for governing conduct, its impracticability is demonstrated daily ... In the case of an organ donation for a therapeutic purpose by a live donor, ... we do not find this conduct offensive to fundamental values, even though, in the case of a kidney transplant, the donor may be taking a risk, since the remaining kidney may later fail.¹⁰

The majority's counter-argument is not, however, convincing because it assumes that the life-threatening situation of a person in need of a kidney transplant is analogous to that of a couple wishing to have a child or more children. As argued in Part 4, organs may be donated but not sold, unlike the children contemplated in the paid preconception arrangements. Further, it assumes that the relationship of a person to one of his or her two healthy kidneys is similar to that of a mother to her child: that children, like kidneys, are fungible.

The majority considered a third argument advanced by opponents of the practice: there are physical risks to the carrying woman. To this, the majority replied, "While they certainly do exist, the [medical risks] can be minimized by providing proper medical care [and they] can be

communicated and need not be assumed by anyone with even a residuum of doubt."¹¹ The majority do not address the concern that the practice of genetic-gestational preconception arrangements entails that significant risks to health are borne exclusively by one party for the benefit of others who bear no physical risks themselves.

The fourth argument advanced by opponents and considered by the OLRC majority was the danger of psychological harm to the carrying woman and the child arising from the transfer of custody after birth. The majority's surprising response was, "We wish to indicate that, at this juncture, the effects of surrendering custody on mother and infant are not evident."¹² Here the majority might have usefully addressed the question of why they believed there is insufficient evidence of psychological harm to mother and child caused by relinquishment, given that such evidence exists in literature related to adoption.¹³ Perhaps the majority believed that a woman who agrees in advance of conception to surrender her child experiences relinquishment in an entirely different way than a woman who, once pregnant, decides to surrender the child for adoption. Yet both groups of women conceive and gestate a child for whom they must undergo the discomfort of pregnancy and the pain of labour and childbirth. Both groups of women usually surrender their newborn child to strangers. It would have been interesting to know why the similarities in the experiences of these women were not considered more relevant than the differences.

Further, the OLRC majority might have usefully discussed why the ample literature on the psychological effects of adoption on the adopted child have no relevance. In both practices, the child is separated from the woman who carried him or her and is not likely to be permitted to come to know that woman. If this experience causes harm, it is likely to cause harm to both groups of children. In light of the extensive social scientific literature on relinquishment of a child by its mother in adoption,¹⁴ and the many anecdotal accounts of the experience by both women and children,¹⁵ it would have been helpful to learn why the majority believed that "the effects of surrendering custody ... are not evident."¹⁶

Notably absent from their discussion of arguments opposed to the practice of preconception agreements is any consideration of its potential harm to the carrying woman's other children. As discussed in Part 3, these children who witness and often feel the development of the fetus may wonder if they too will be sold to strangers. Although the majority do not consider this concern when addressing arguments of principle, they do regard it as a practical matter that might inhibit the court approval of an agreement. The majority state that the court should not approve the involvement of a woman when the emotional stability of an otherwise secure child is at risk.¹⁷

The fifth argument the majority considered was that handicapped children born of preconception agreements might be loved by neither the commissioning couple nor the carrying mother. The OLRC majority stated that this concern could be addressed by legislation: the commissioning

couple would be obliged to accept the child. Yet the OLRC acknowledged that the law could not force the couple to care for the child: "If the social parents do not wish to accept custody of the child, they cannot be compelled to do so as a matter of law or as a practical matter, and the children's aid society will undoubtedly intervene."¹⁸

Having canvassed and discussed the arguments opposed to the practice, the OLRC majority decided that prohibition was unwarranted because "recourse to medical means of alleviating the effects of infertility or genetic impairment cannot conscientiously be forbidden ... By assisting an otherwise childless couple, surrogate motherhood may be the sole means of affirming the centrality of family life."¹⁹

The language used by the OLRC requires comment because it disguises the nature of the agreement under consideration. What the majority refer to as "medical means of alleviating the effects of infertility" is not a procedure performed on an afflicted person but the assumption by a third party of risks to mental and physical health. As was discussed in Part 4, the premise of the majority that preconception arrangements constitute medical treatment is ill founded.

The OLRC majority endorse the practice also because by "assisting an otherwise childless couple, surrogate motherhood may be the sole means of affirming the centrality of family life." In suggesting that the practice of preconception agreements gives children only to couples who have none, the OLRC majority discount the many cases where couples already have children in their home and yet commission the conception of another;²⁰ the commissioning couples are not always childless. Nor would the majority require evidence that the commissioners do not already have children. Further, and more significantly, the majority do not discuss the fact that in placing the child in one home, a preconception agreement necessarily removes it from another, often at the expense of the family life of the carrying woman and her husband (or partner) and her other children. In weakening the concept of the mother-child bond (by sanctioning its deliberate, calculated rupture), the practice can hardly be said to affirm "the centrality of family life."

Despite these serious issues, the OLRC majority found preconception agreements neither immoral nor anti-social. The majority's view that prohibition would be an inappropriate response was strengthened by their belief that the practice would carry on in any event, and its potential dangers would increase if it were driven underground by prohibitive legislation.

For these reasons, the majority recommended the enactment of a regulatory legislative scheme. It would entail that the prospective commissioning couple and carrying woman reach a written agreement that, at a minimum, addresses certain matters specified by legislation. Before conception, the parties would be required to submit their agreement to the Provincial Court (Family Division or the Unified Family Court, where applicable) to obtain its approval. At the approval hearing, the court would

be required to assess the suitability of the parties involved, the terms of the agreement, and the payment to the carrying woman. The regulatory scheme would also make provision for instances where the carrying woman refuses to relinquish the child, for resolution of custody questions pertaining to the birth of a handicapped child, and for the status and inheritance rights of the child.

In assessing the suitability of the commissioning couple, the court would require proof of a medical reason for resorting to preconception agreements. The majority wished to avoid instances where the commissioning woman prefers "not to disrupt other endeavours, such as a career, or [wishes] to avoid the physical effects of pregnancy."²¹ The majority state that "our sole purpose in allowing individuals to pursue surrogate motherhood arrangements under strict control is to respond to infertility, not to afford individuals the opportunity to satisfy their lifestyle preferences."²² The majority do not further define "infertility" or what constitutes a "lifestyle preference."²³

In assessing suitability, the court would be required to examine the marital status of the commissioning couple, the stability of their union, and their individual stability to be sure that the intended child will be provided with an "adequate upbringing." It is interesting to note that the majority do not recommend that the commissioning couples undergo a home study to assess their suitability. It is sufficient for the majority that they be able to provide a prospective child with "an adequate upbringing,"²⁴ but how this will be determined is unclear. The majority were divided over the question of whether a commissioning couple ought to be married. However, the fact that the couple might cease to be together was contemplated by the majority in their recommendation that the parties be required to consider, and agree on, arrangements for the child should the intended social parents cease to live together as a couple.²⁵

Where the sperm comes not from the commissioning man but from a third party, or where the ovum is donated by a woman other than the carrying woman or the commissioning woman, the majority recommended that the gamete donors should have no standing in the proceedings and that the donors "should have no legal relationship to the child ... in other words, a donor should have no parental rights or duties regarding the artificially conceived child."²⁶ Without discussion as to the best interests of the child, they further recommended that the child be unable to learn the identity of its genetic parents.²⁷

With respect to the suitability of the carrying woman, the majority recommend that under no circumstances should a woman be approved as a carrying woman when she is less than 18 years of age. The judge should also inquire into her physical and mental health. There should be evidence that she does not carry any deleterious genetically transmissible condition although such evidence is not specified to be required of the commissioning man or the sperm donor (as the case may be). Her mental state is important from the majority's perspective because, in the first instance, it

might affect the commissioning couple — "it affects whether she will be conscientious in adhering to her agreement."²⁸ The majority recommended judicial approval of the carrying woman because, in the second instance, it "may also be of importance to the woman herself."²⁹ Acknowledging that "certain physical and psychological risks would appear to be associated with participating as a surrogate mother," the majority thought it advisable "to exclude from participation in surrogate motherhood arrangements women who are demonstrably unsuited to their role, either because they are patently maladjusted or unstable, or because they clearly do not appreciate the nature of surrogate motherhood."³⁰ Accordingly, the majority recommended that the court be required to examine evidence regarding the physical and mental health of the prospective carrying woman. Counsel for the prospective commissioning couple or her own counsel would be required to submit reports by doctors, psychologists, or other professionals.³¹

In discussing whether "the opportunity to participate as a surrogate mother"³² should be restricted to certain categories of women, the majority made some telling observations. The criteria they considered for restricting categories of women from participating would eliminate most women.

It has been argued, for example, that such participation should be limited to women who already have given birth to children, because only they can truly appreciate the risks associated with pregnancy and the implications of surrendering a child upon birth. Alternatively, it has been said that women with children should not be allowed to be surrogate mothers because these children may be traumatized upon surrender of the infant, fearing that they too will be given away. In addition, some commentators have suggested that married women are to be preferred, in the expectation that their husbands will be bulwarks of emotional support; others have taken an opposite view, in the belief that husbands will be potential sources of conflict.³³

Thus, the majority acknowledged that participation is problematic for all women: women with children and those without children, and women with a partner and those without. Rather than addressing this rather significant concern, the majority simply stated that "there is no theoretical or empirical basis upon which to adopt a categorical approach to the eligibility of women to serve as surrogate mothers."³⁴

Nevertheless, the majority do recognize that these concerns might have practical importance if a carrying woman conceives; they require the court to consider the prospective carrying woman's domestic situation.

If there are indications that [the carrying woman's other children] might be psychologically harmed by her participation and, in particular, by the planned transfer of custody, a court should not approve her involvement. It would be unconscionable to sacrifice knowingly the emotional stability of an otherwise secure child in the interests of creating another child.³⁵

In addition to examining whether a carrying woman's children are likely to suffer, the court would be required to investigate whether her partner agrees with her intended pregnancy.

We believe that, where prospective surrogate mothers have partners in marital or nonmarital unions, the disposition of these partners to their participation in surrogate motherhood arrangements should be a factor to consider. Where a partner is opposed to her participation, this may augur badly for the woman's state of mind during the pregnancy. This, in turn, may be harmful to the fetus and deleterious to the stability of the surrogate mother's family.³⁶

This statement raises a number of questions. It is curious that the majority did not also require the court to inquire into the domestic circumstances of the prospective commissioning couple. It is possible that a commissioning woman might have, at the very least, ambivalent feelings about raising her husband's or partner's child by another woman. This too might "augur badly for the woman's state of mind" and might in turn "be harmful" to the child who is to be raised by a woman who might have acquiesced with great reluctance to her husband's or partner's wishes.

It is also curious that when the majority considered whether preconception agreements were justifiable in principle, they rejected arguments based on psychological risk to the mother and child of severing their relationship. "Particularly speculative, we understand, is the present state of knowledge about the degree of bonding of the infant in the womb. In view of this uncertainty, we are not persuaded that prohibition is warranted."³⁷ Yet in the practical application of their view that pre-conception agreements ought to be regulated, the majority did recognize the intimate relationship of mother and child: they suggested that potential lack of agreement between the mother and her husband or partner might be sufficiently harmful to the fetus as to prevent the participation of the woman. If the majority consider that a woman's distress from a lack of marital harmony might harm her fetus, it is odd that the majority do not believe that a woman's distress at the prospect of losing the child at birth might also harm the fetus. If maternal emotional distress is sufficient to harm a fetus, one might argue that, in the best interests of the child, the carrying woman be permitted to resile from the preconception agreement to alleviate her, and consequently her fetus's, distress.³⁸

Under the OLRC's proposal, the role of the court would be to assess the suitability of the parties on the basis of the evidence they present, and to hear from a children's aid society, which would have received notice of the hearing, and would have standing to adduce evidence of unsuitability, but would do so not on the basis of a home study, which the majority eschew.

The standard of proof would be the civil standard, the balance of probabilities. The prospective carrying woman would necessarily be a co-applicant, but should the parties to the application wish to remain

anonymous to one another, the court could hear from the parties separately. The carrying mother, though a co-applicant, would be required to have separate legal representation. "To reduce ... unnecessary uncertainty respecting the parentage of a child, and to limit the opportunity of a surrogate mother to refuse to surrender the child on the ground that it is not the child of the approved arrangement,"³⁹ records would be required to be provided to the court of the blood groups and other relevant biological characteristics of the adults involved: the carrying woman, her husband or male partner, if any, and the persons who produced the gametes used. The application hearing would be *in camera* and the court records would be sealed to protect the privacy of the parties because "the sensitivity and intimacy that we associate with human reproduction is accentuated significantly in the circumstances of artificial conception."⁴⁰ Curious here is the use of the word "intimacy" to describe the relationship between the parties who, the majority envision, would remain unknown to each other.

In addressing the question of what terms should be in the agreement, the majority determined that some would be mandated by the regulatory scheme and others would be open to discussion by the parties.

The most controversial term that would be in every preconception agreement approved by the court is that a child born pursuant to the agreement must be surrendered immediately at birth to the social parents. Where a carrying woman refuses to transfer the child, the court would order that the child be delivered to the commissioners. In addition, where the court is satisfied that the carrying woman intends to refuse to surrender the child at birth, the court, prior to the birth of the child, would be empowered to make an order for transfer of custody at birth.⁴¹ The majority recognized that to compel a mother to surrender her newborn infant "would seem to strike at the very heart of our shared values," yet they believed it was necessary "to avoid uncertainty and conflict upon the birth of the child."⁴² Here the majority create a false opposition, *viz.*: between the central value of keeping mothers and babies together, on the one hand, and the desire for certainty and lack of conflict, on the other. These can be united in a rule that states that the birth mother is entitled to custody of the commissioned child unless she chooses to relinquish it in accordance with adoption law.

Nevertheless, the majority claimed to find guidance for their recommendation in contract and adoption law. Specific performance of a contract, though an unusual remedy, can be granted in cases where the subject matter of the contract is unique and money damages will not be adequate recompense, and where to enforce the agreement will not require judicial supervision. The majority reasoned that specific performance was an appropriate remedy in both respects: the child is unique and money would not recompense the commissioning couple, and secondly, the transfer of the child is a discrete act that the court could supervise. To make this suggestion, however, the majority arguably likened a child to a

commodity under a production contract and implied that commercial law principles can justify a court order to take a child from its mother.

Although the majority acknowledged that family law in Ontario prevents any agreement from superseding the court's inherent jurisdiction to decide custody in the best interests of the child, they claimed to find guidance also in adoption law — even though the Child Welfare Act, R.S.O. 1980, c. 66, provides that an adoption order requires the consent of the parents of the child or the persons having lawful custody of the child, and that consent cannot be given until after the child is seven days old and may be withdrawn within 21 days after it has been given.

In choosing between the two regimes — specific performance of a commercial bargain or the grace period offered mothers by adoption law — the majority stated that "in the first case, the risk of disappointment and trauma rests on the surrogate mother, while, in the second, it is placed on the social parents."⁴³ The majority decided that the more important question is what resolution would serve the best interests of the child. For the answer, they turned in vain to scientific literature: "Unfortunately, the available scientific literature would appear to indicate no clear answer to the question." But the experts — "the Advisory Board that assisted the Commission, which included a child psychiatrist and a social worker" — favoured immediate surrender to the commissioners. The reason they did so is one of several instances of how, in their reasoning on the issue of specific performance, the majority *presume* the result to *justify* the result. The advisory board favoured immediate surrender because this "would serve to prevent bonding with the surrogate mother and to facilitate bonding with the person — the social mother — who, in the vast majority of cases, would be the ultimate recipient of the child."⁴⁴ It is extraordinary that the majority attempt to justify the argument that a court ought to force the carrying woman to surrender the child to the commissioners on the basis that the court *will* award custody to the commissioners. If the proposed regime did not require a fit carrying woman to surrender her child, custody would not be an issue.

The second justification for court-ordered surrender of the child is equally spurious.

It may seem harsh and unfeeling to countenance a situation where, in the face of continuing recalcitrance, officers may be ordered to deliver the infant to the social parents. Yet physical seizure of a child may be effected under the present law in the context of a dispute over custody.⁴⁵

The law to which the majority refer is Sec. 37(2) of the Children's Law Reform Act, R.S.O. 1980, c. 68, which permits the court to order the sheriff or police officer to seize a child if the court is satisfied that any person is unlawfully withholding a child from a person entitled to custody or access. Again, it is extraordinary that a law reform commission should justify a law that would have the police take a child from its mother, on the basis that the court has power to seize children when people are holding them

unlawfully. With this circular reasoning, the majority beg the questions of what constitutes lawful behaviour and what ought to be considered "unlawful" in the behaviour of a woman who gives birth to and wishes to raise her child.

The final attempted justification for specific performance of an approved preconception agreement is that the courts have taken children from their mothers when they have ruled that the children are in need of protection. Yet, the majority would not require a similar finding of maternal unfitness before forcing the carrying woman to give up the child to the commissioners.

Therefore, the majority do not make a case for specific performance of preconception arrangements. They do, however, contemplate a situation where specific performance would not be awarded automatically. This is where evidence of the unsuitability of one or both of the members of the commissioning couple has come to light. "An extreme example might be the conviction of a social parent for commission of a serious offence, such as sexual assault of a child."⁴⁶ The court would be empowered to rescind its approval of the agreement on the application of the carrying woman or a children's aid society who had evidence of the commissioners' unsuitability.

Apart from the issue of whether the law would mandate that the carrying woman be forced to surrender the child, the second most contentious issue was whether the financial terms of the arrangement would be fixed by the court. In the result, the majority were not agreed. They identified four possible types of payment (fee in the way of profit, expenses incurred, lost income and opportunity, and pain and suffering), and decided only that the court must approve the payment. As noted above, the majority stated that judicial approval would ensure that there is no financial exploitation of the parties. The majority did not address the argument that any payment constitutes payment for the sale of a baby and is, therefore, *per se* exploitative of the carrying woman, and commodifies a human being.

With respect to handicapped children born pursuant to a preconception agreement, the majority stated that the agreements need not provide that the commissioners have responsibility for a handicapped child, because under the majority's proposals the commissioners would be the parents for all purposes. The parties to the agreement should, however, be required to address the possibility that the child would need extraordinary care immediately upon birth and the commissioners might not be available. The power to make a decision about care should be delegated in a preconception agreement to, for example, the carrying woman or the attending physician.

The majority discuss a fourth term of preconception agreements: the possibility that an abortion might be sought at the insistence of either the commissioners who, for example, did not like the results of an amniocentesis test, or the carrying woman who no longer wished to

participate in the arrangement. The majority decided that given the body of law governing abortion that was then developing,⁴⁷ it would be inappropriate to make a proposal respecting the possibility of abortion, and that the issue ought to be resolved within that larger context.

Beyond the four controversial matters — specific enforcement, payment, responsibility for handicapped children, and abortion — there were other terms the court should require the parties to consider and agree on:

1. health and life insurance protection for the carrying woman;
2. arrangements for the child should one or both of the commissioners die before the birth of the child;
3. arrangements for the child should the commissioners cease to live together as a couple;
4. circumstances regarding the particular manner in which immediate surrender of the child to the commissioners is to be effected;
5. the right, if any, of the carrying woman to obtain information respecting, or to have contact with, the child after surrender;
6. prenatal restrictions on the carrying woman's activities before and after conception, including dietary obligations;
7. conditions under which pre-natal screening of the child may be justified or required, for example, by ultrasound, fetoscopy, or amniocentesis.⁴⁸

In requiring the parties to address these issues, the court would not require any particular resolution other than that it be in the interests of the child and otherwise fair and equitable.

The majority then addressed the questions of the status of the child and its rights to inheritance. Consistent with their view that certainty is a high priority, the majority recommended that the status and parentage of the child should be established immediately and in favour of the commissioners. Once the carrying woman gives birth, the commissioning parents should be recognized as the parents of the child for all legal purposes and the carrying woman should have no legal relationship to the child. Further, children born under such agreements should acquire inheritance rights through the approved parents and should not have inheritance rights against the carrying woman.⁴⁹

Surprisingly, the majority did not specifically recommend that it be illegal for commercial brokers to operate for profit. However, the majority did recommend that any broker or agency must be licensed by the Ministry of Community and Social Services, which would make regulations concerning the credentials of agency operators, the calibre of their staff, advertisement and recruitment practices, services offered, and fees charged.⁵⁰

The majority of the OLRC made a number of miscellaneous provisions that contemplate how to treat the carrying woman should the artificial conception technology fail. These are significant because they would undermine the majority's avowed concern to protect *all* the parties to an agreement. The first provision deals with the uncommon situation where a woman is hired to conceive and then to submit to a procedure to flush the conceptus from her uterus. Should the flushing procedure fail, the woman would remain pregnant. Rather than addressing the situation from the perspective of the woman who expected that her pregnancy would end with the flushing procedure, the majority consider the matter only from the perspective of the commissioning couple. They suggest "that it would be salutary if, upon diagnosis of the pregnancy, the woman were to be allowed to agree with the couple that, upon birth, the child will be surrendered to them, and that she will continue her pregnancy as a surrogate mother."⁵¹

A second instance where the technology influences the majority's response is where an embryo is conceived *in vitro* and the woman who had agreed to bear the child decides to resile from her agreement. With the telling words, "surrogate mothers should not feel constrained to honour their promises if, in fact, they do not wish to participate," the majority suggest that the court permit an expedited summary hearing to approve her "replacement." In cases where the embryo must be transferred within a limited period before it perishes, the majority stated that, "owing to the exigencies of the situation, the suitability of the replacement surrogate mother may properly be assessed in a summary manner."⁵² Not only because it places a birth mother at two removes from the child by the extraordinary name "replacement surrogate," this miscellaneous provision is remarkable. Whereas the majority earlier emphasized the importance for the carrying woman, her husband or partner, and her children of inquiring into her "suitability" to participate and the prevention of her exploitation, the "rigorous judicial screening" of the woman could be hastily set aside because the commissioning couple's embryo is in a petri dish and is in danger of perishing if a "replacement surrogate" is not found quickly. This recommendation was clearly made with consideration for the potentially disappointed expectations of the commissioning couple, but without regard for the woman whom the majority call the "replacement" and whose exploitation the regulatory scheme is ostensibly designed to prevent.

The final matter the majority considered in propounding their regulatory scheme was the appropriate penalties for circumventing the regulatory scheme and the status of a commissioned child whose parents thus circumvented the scheme.

With regard to penalties for circumventing the regulatory scheme, the majority believed that to render such agreements unenforceable would be an insufficient penalty. To prevent people from ignoring the regulatory scheme, the majority recommended that the penalty be a fine but not imprisonment. Presumably the fine would fall on both the commissioners and the carrying woman; as we have seen, their ability to absorb a financial

penalty varies considerably, and therefore might not (depending on the amount of the fine) act as a deterrent to commissioners.⁵³

Surprisingly, the fact of the parties having circumvented the regulatory scheme would not jeopardize the commissioners' ability to obtain custody of the child.

We suggest that the child's best interests would be served by giving certainty to its relationship with the social parents, notwithstanding the fact this may produce the precise result sought in the impugned arrangement. To deny the social parents the opportunity of regularizing their relationship with the child, as a means of discouraging unapproved arrangements, would have the effect of punishing the children for the conduct of their parents.⁵⁴

Given the care the majority take to suggest that a regulatory scheme will prevent exploitation of carrying women, it is startling that commissioners who circumvent the regulatory scheme would nevertheless be regarded at law as the parents of the child. The majority assume that it is in a child's best interests to be placed with commissioners who unlawfully refused to abide by a regulatory scheme designed to prevent, *inter alia*, their exploitation of the child's mother. It appears here that the majority are prepared to jettison the fundamental justification for the regulatory scheme — the protection of all the parties — if by doing so the legislative proposal will ensure that the commissioners receive the child.

In summary, the OLRC majority, in a poorly argued report, claimed that preconception arrangements are neither immoral nor anti-social and that their prohibition would lead to underground agreements that might exploit women. As a consequence, the OLRC majority recommended that the Ontario legislature enact a comprehensive legislative scheme requiring the parties to seek judicial approval before participating in preconception arrangements and making approved agreements specifically enforceable.

Notes

Notes to Part 1

1. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985), 219 [hereinafter OLRC].
2. The Infertility Center of New York operated by Noel Keane "has arranged 10 surrogate births in the past decade" for single men. "Social Studies," *Globe and Mail* (14 May 1992): A18. In the report commissioned by the Law Reform Commission of Canada, of 76 cases involving Canadians and U.S. agencies, one case concerned a child commissioned by a single man. M. Eichler and P. Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians*, report prepared for the Law Reform Commission of Canada (Toronto: Ontario Institute for Studies in Education, 1988), 14.

3. M.A. Field, in her book, *Surrogate Motherhood* (Cambridge: Harvard University Press, 1988), states on page 5 that the typical fee is \$10 000 (U.S.). The Center for Surrogate Parenting, Inc. of Beverly Hills, California, similarly lists the fee paid to carrying women as \$10 000 (U.S.). Gwynne Basen, a Montreal filmmaker, who visited that firm in July 1990, reported in a private communication that the sum paid to carrying women had been increased to \$12 000 (U.S.). In England for exclusively gestational arrangements, the "going rate is about £6 000" or \$12 500 (Cdn.) according to Professor M. Macnaughton in "Trouble in the Family Way," *The Times* (23 August 1990).
4. N.P. Keane with D.L. Breo, *The Surrogate Mother* (New York: Everest House, 1981), 57 *et seq.*
5. See below in this part, "Brokers."
6. Noel Keane's Infertility Center of New York issued literature in 1989 stating that its fee was \$11 000 (U.S.). In 1988, the Center for Surrogate Parenting, Inc. of Beverly Hills, California, advertised in its own publication that the amount payable to the Center was \$16 600 (U.S.) "for complete coordination and administration of each case."
7. See the subsection "Brokers" of "The Effect of Third Parties' Interests and Activities" in Part 3.
8. The first British carrying woman in England, who surrendered her child to an American couple in 1985, announced in February 1988 that she was organizing a non-profit "information and help-line service" for people who wish to commission a child or who wish to bear and surrender one. The organization, called "COTS: Childlessness Overcome Through Surrogacy," was formed as a charity, so that money would not be involved, which would be illegal under English law. A. Neustatter, "A Campaign for Compassion," *Sunday Times of London* (21 February 1988): C3; A. Ballantyne, "Agency Will Offer Babies Without Birth," *Sunday Times of London* (19 August 1990).
9. W. Greengross and D. Davies, "Expression of Dissent: Surrogacy," in M. Warnock, *A Question of Life: The Warnock Report on Human Fertilisation and Embryology* (Oxford: Basil Blackwell, 1985), 87.
10. One of the questions posed by New South Wales Law Reform Commissioners is whether arrangements, if they are to be regulated, ought to be subject to the approval of the court or of a government agency. New South Wales Law Reform Commission, *Artificial Conception: Discussion Paper 3, Surrogate Motherhood* (Sydney: The Commission, 1988), 130.
11. *A v. C*, [1985] F.L.R. 445; *Re an Adoption Application (Surrogacy)*, [1987] 2 All E.R. 826 (U.K. Fam. Div.); *Re P (Minors) (Wardship: Surrogacy)*, [1987] 2 F.L.R. 421.
12. D. Morgan, "Surrogacy: An Introductory Essay," in *Birthrights: Law and Ethics at the Beginnings of Life*, ed. R. Lee and D. Morgan (London: Routledge, 1989), 66.
13. Eichler and Poole, *supra*, note 2.
14. *Ibid.*, 15.
15. *Ibid.*, 13-14.
16. The 32 agreements were undertaken between March 1980 and March 1989 and involved 32 Canadian couples. Not all the cases resulted in children being born.

Of the 32 cases, 13 were completed: each commissioning couple had a child. In three, the commissioning couples were still undergoing adoption proceedings. Three couples had given up after unsuccessful attempts to conceive a child. In 10 cases, insemination was taking place as the report was being written. Two couples terminated the attorney-client agreement before a genetic-gestational woman was selected. In one case, no information was available.

Of the 32 Canadian couples, eight used two genetic-gestational women each, two used three such women, three used four, and one used six. (Presumably, more than one woman was used because conception did not occur in the first woman.) "Overall, then, a total of 55 potential or actual [genetic-gestational women] were involved in the 32 cases." *Ibid.*, 32.

Geographical information was available on 27 commissioning couples. Twenty-two were from Ontario, three from Quebec, and one each from Alberta and Manitoba. Of the genetic-gestational women about whom the researchers had information, 19 were from Michigan, two from Ohio, one from North Carolina, and one from London, Ontario. *Ibid.*, 30-34.

17. "In order to appreciate this finding [that there is proof of 118 Canadian cases of preconception arrangements], it must be remembered that we have been extremely stringent in excluding cases if there was any doubt concerning them. We thus feel confident that these numbers represent a very conservative estimate which probably greatly underestimates the real extent of the phenomenon." *Ibid.*, 45.

18. *Ibid.*, 24 and 45.

19. (U.K.), 1985, c. 49.

20. Morgan, *supra*, note 12, 67 (emphasis in original).

21. *Ibid.*, 68.

22. An August 1990 article in *The Times* reported that the Bourn Hall Clinic, near Cambridge, had instituted a program of implanting the embryo of a couple into the uterus of another woman. The service would cost couples £2 500 (approximately \$5 300 Cdn.) for each attempt at a pregnancy. The clinic would not pay the gestational woman but the commissioners would pay her expenses and could compensate her for loss of earnings during the pregnancy. A. Ballantyne, *supra*, note 8. According to an article in *The Times* that appeared on 23 August 1990, the Bourn Hall Clinic is not the first to implant a frozen embryo into a gestational woman, but it is the first to discuss the issue openly. In August of that year, the clinic had transferred two embryos into gestational women; in both cases, the gestational women were sisters of the genetic women. The practice of implanting embryos into gestational women appeared likely to grow as the clinic was considering commencing the procedure on some of the many people on its waiting list. A. Kent, "Trouble in the Family Way," *The Times* (23 August 1990): 13.

23. Martha Field estimates the number of births initiated by preconception arrangements to have been 500 at the end of 1986 (Field, *supra*, note 3, 5). The U.S. Office of Technology Assessment (OTA) report suggests the figure is 600. U.S. Congress, Office of Technology Assessment, "Legal Considerations: Surrogate Motherhood," in *Infertility: Medical and Social Choices* (Washington, DC: U.S. Government Printing Office, 1988).

24. California, Joint Legislative Committee on Surrogate Parenting, "Minority Report to the California Legislature," in *Commercial and Non-Commercial Surrogate Parenting* (Sacramento: Joint Publications Office, 1990), M7-M9.
25. New South Wales Law Reform Commission, *supra*, note 10, 11.
26. A v. C, [1985] F.L.R. 445, Family Division, 20 June 1978; Court of Appeal, 18 July 1978. Neither the judge at first instance nor the Lord Justices in the Court of Appeal mention a written agreement; it therefore appears that there was no written agreement between the parties.
27. Ibid., 446-47. When the carrying woman refused to relinquish the child, the commissioning man sued. The case ultimately went to the Court of Appeal, where he was denied custody and access.
28. B.M. Dickens, "Legal Aspects of Surrogate Motherhood: Practices and Proposals," paper presented at the U.K. National Committee of Comparative Law 1987 Colloquium, "Legal Regulation of Reproductive Medicine," Girton College, Cambridge, England, 15-17 September 1987, 5-6.
29. K.M. Brophy, "A Surrogate Mother Contract to Bear a Child," *Journal of Family Law* 20 (1981-82): 263-91. According to the article, Ms Brophy is an attorney "in private practice in Louisville, Ky., where she assists infertile couples in the surrogate procedure through Surrogate Family Services [Parenting Associates], Inc., a Kentucky corporation" (p. 263). The corporation's literature states that the firm is run by Richard Levin, a medical doctor who specializes in reproductive endocrinology and infertility.
30. The "Surrogate Parenting Agreement" was sent in October 1988 in reply to a letter of inquiry addressed to the offices of Mr. Noel Keane, 930 Mason, Dearborn, Michigan 48124, U.S.A.
31. Ibid., paragraph 25.
32. Noel Keane, "Attorney-Client Agreement, 1988, Exhibit 'A.'" "Statement of Charges Incident to the Surrogate Service."
33. According to the American Fertility Society, scientific attention has not been paid to the medical aspects of preconception agreements because the practice has developed "in an entrepreneurial setting, generally apart from medical institutions." American Fertility Society, Ethics Committee, "Ethical Considerations of the New Reproductive Technologies," *Fertility and Sterility* 53 (Suppl. 2)(1990), 68S.
34. Eichler and Poole stated that commercial arrangements probably differ in significant ways from private arrangements. For example, in private arrangements involving friends and relatives, it is possible that the friend or relative who agrees to carry the child is much more similar to the father's wife in terms of age and socioeconomic status than would be a carrying woman whom the commissioning couple met for the first time through a broker. Eichler and Poole, *supra*, note 2, 45.
35. See P.J. Parker, "Surrogate Motherhood, Psychiatric Screening and Informed Consent, Baby Selling and Public Policy," *Bulletin of the American Academy of Psychiatry and the Law* 12 (1984): 21-39.
36. "Philip Parker, the Detroit psychiatrist who does most of Keane's testing, processes each applicant in a matter of hours, usually for a flat fee of \$250." M.

Gladwell and R. Sharpe, "Baby M Winner: Meet the Surrogacy Entrepreneur," *New Republic* (16 February 1987), 16.

37. P.J. Parker, "Motivation of Surrogate Mothers: Initial Findings," *American Journal of Psychiatry* 140 (1983): 117-18. Parker presented an updated report in April 1984 with a sample of 30 women. "The Psychology of the Surrogate Mother: A Newly Updated Report of a Longitudinal Pilot Study," presented at the American Orthopsychiatric Association General Meeting, Toronto, 9 April 1984. The second study is cited for demographic information because, unlike the first, which considers persons who wish to act as carrying women, it reports information on women who actually participated in a preconception arrangement.

38. This report, with a sample size greater than 334 carrying women in commercial agencies, was compiled by the OTA. It contains only demographic data. See *Infertility: Medical and Social Choices*, *supra*, note 23, 274, Table 14.1.

39. The OTA summarizes the results reported by K. Linkins et al., H. Hanafin, P.J. Parker, and D.D. Franks. Although Parker's study is available because it has been published, the other studies have not and therefore are not relied upon in this report.

40. See L.B. Andrews, *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies* (New York: Harper and Row, 1989), 6 *et seq.*

41. Eichler and Poole, *supra*, note 2.

42. Parker, "Psychology of the Surrogate Mother," *supra*, note 37.

43. *Ibid.*, 7.

44. E. Kane, *Birth Mother* (San Diego: Harcourt Brace Jovanovich, 1988), 16-31.

45. Patti Foster, interviewed on "Shirley," CTV, 1 February 1991.

46. A.T. Flemming, "Our Fascination with Baby M," *New York Times Sunday Magazine* (29 March 1987), 33.

47. Eichler and Poole, *supra*, note 2.

48. *Ibid.*, 39. The statistics given were year of birth but do not indicate what year the child was born. It appears, therefore, that the information concerns age at the time the research was conducted.

49. *Ibid.*, 41.

50. *Ibid.*, 34.

51. *Ibid.*, 42-43. Of 20 commissioning couples, seven men and eight women were Jewish, six men and eight women were from various Protestant churches, and five men and two women were Catholic.

52. *Ibid.*, 35.

53. *Ibid.*

54. *Ibid.*

55. The commissioning men's occupations were: bricklayer, business owner, carpenter, construction business owner, dentist, doctor (internist), doctor, engineer (4), rancher, financial analyst, lawyer (2), optometrist, robotics, self-employed (2), sound systems designer, statistician, teacher. *Ibid.*, 38-39.

The commissioning women's occupations were: unknown, business manager (2), supervisor, nurse, housewife (2), doctor (surgeon), dietician, professor, teacher (6), secretary, quality control manager, bank worker, medical technician, postgraduate work, clerk. Ibid.

The carrying women's occupations were: accounts receivable collector, cashier, co-owner of a tree service, credit administrator, hostess at a restaurant, housewife (10), inventory clerk, nurse, sales clerk (full-time) (2), sales clerk (part-time), secretary, social worker, student (2), unemployed (2), waitress. Ibid., 36.

The carrying women's partners' occupations were: assembly worker in a factory, bricklayer, carpenter, co-owner of a tree service, electrician, industrial engineer, labourer, machine operator, machinist, mechanic, mechanical engineer, recreation department, sales manager, screen painter, sign painter, student, theatre manager. Ibid., 37.

56. Ibid., 44.

57. Genesis 30:1.

58. S. Downie, *Babymaking: The Technology and the Ethics* (London: Bodley Head, 1988), 10.

59. New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (Albany: 1988), 12.

60. T. Nabors, "Clinical Treatment of the Infertile Couple," *Technological Powers and the Person: Nuclear Energy and Reproductive Technologies* (St. Louis: Pope John XXIII Medical-Moral Research Center, 1983), 389.

61. J.N. Lasker and S. Borg, *In Search of Parenthood: Coping with Infertility and High-Tech Conception* (Boston: Beacon Press, 1987), 28.

62. M. Ignatieff, "All Shook Up: The Self and Its Crisis — Lecture 3: Love," Larkin Stuart Lectures, Trinity College, Toronto, 10 November 1988. (Quoted with the kind permission of the author.)

63. That there are fewer babies for adoption today is clear from the number of babies placed by government agencies. For example, the Metropolitan Toronto Children's Aid Society in 1969 placed 1 239 children for adoption of whom 961 were less than one year old; in 1985, despite the increase in the city's population, only 141 adoptions were completed by the agency. Children's Aid Society of Metropolitan Toronto, "Adoption Today," *Our Children* 14 (Winter 1979): 5; Children's Aid Society of Metropolitan Toronto, *Annual Report*, 1985; R. Walker, "The Market in Babies," *Canadian Lawyer* 11 (February 1987): 20. See also B.D. Gradstein, M. Gradstein, and R.H. Glass, "Private Adoption," *Fertility and Sterility* 37 (1982): 548-51.

64. Whereas in 1968, 30.1 percent of unwed mothers kept their children, 88.3 percent did so in 1977. Ontario, Provincial Secretariat for Social Development, *The Family as a Focus for Social Policy* (Toronto: 1979), 19, Table 8, quoted in OLRC, *supra*, note 1, 16. See also R. Lindsey, "Adoption Market: Big Demand, Tight Supply," *New York Times* (5 April 1987): A1.

65. One commissioning man described the importance to him of rearing a child to whom he is related:

Maybe it's egotistical ... but I want my own child. Adoption leaves me cold. I guess for some women, as long as they have a child, it's fine. But for me, it's like if I see my child do something, I need to know that he's really mine.

(Keane and Breo, *supra*, note 4, 29-30.)

66. One woman, upon hearing that the carrying woman had become pregnant, said, "I wanted to put Carol under a glass bowl. You know, don't do this, don't do that. Are you eating right? Are you drinking enough? Are you taking your vitamins?" *Ibid.*, 82.

In Mary Beth Whitehead's pregnancy, the commissioning woman, Betsy Stern, a physician, seemed to Mary Beth Whitehead "to appropriate the pregnancy, doing things like calling Mrs. Whitehead's doctors, even recommending to him a certain drug [that she] should take." Flemming, *supra*, note 46, 87.

"Mary Beth Whitehead says she felt that Elizabeth Stern was trying to take over her life ... Stern insisted that Whitehead go ahead with amniocentesis against her obstetrician's advice." "Who Keeps 'Baby M'?" *Newsweek* (19 January 1987), 49.

67. See, for example, OLRC, *supra*, note 1, 237.

68. Eichler and Poole, *supra*, note 2, 26. In his book, Noel Keane described an arrangement between a California couple and an East Coast carrying woman. The carrying woman decided that she wanted to keep her child. The couple threatened to sue but changed their minds when she threatened to respond by revealing that the couple were both born male but that the commissioning woman had had a sex-change operation. Keane and Breo, *supra*, note 4, 197-209.

69. W.H. Utian et al., Letter to the Editor, *New England Journal of Medicine* 313 (1985): 1351-52.

70. A.O. Trounson et al., "Pregnancies in Humans by Fertilization *In Vitro* and Embryo Transfer in the Controlled Ovulatory Cycle," *Science* 212 (1981): 681-82, as cited in W.A.W. Walters and P. Singer, *Test-Tube Babies: A Guide to Moral Questions, Present Techniques and Future Possibilities* (Melbourne: Oxford University Press, 1982), 5. See also R. Weil, "Interview: Alan O. Trounson," *Omni* (December 1985), 83.

71. Downie, *supra*, note 58, 167.

72. See, for example, A. Stuart, "Is It Worth It? I Just Don't Know," in *Infertility, Women Speak Out About Their Experiences of Reproductive Medicine*, ed. R.P. Klein (London: Pandora Press, 1989), 87; R.J. Paulson, M.V. Sauer, and R.A. Lobo, "In Vitro Fertilization in Unstimulated Cycles: A New Application," *Fertility and Sterility* 51 (1989): 1059-60; J. Garcia, "Return to the Natural Cycle for In Vitro Fertilization (Alleluia! Alleluia!)," *Journal of In Vitro Fertilization and Embryo Transfer* 6 (1989): 67-68.

73. D. Navot and N. Laufer, "Assisted Reproductive Technology: A Clinical Appraisal," *Journal of Reproductive Medicine* 34 (1989): 3-9.

74. See the subsection "Brokers" of "The Effect of Third Parties' Interests and Activities" in Part 3.

75. Telephone inquiry to the offices of Noel P. Keane, 930 Mason, Dearborn, Michigan, 28 February 1991, (313) 278-8775. In July 1993 New York law makes brokers' activity illegal in that state. (See the subsection "Statutes" of "United States" in Part 6.)

76. Keane and Breo, *supra*, note 4.

77. *Ibid.*

78. J.S. Kunen, "Childless Couples Seeking Surrogate Mothers Call Michigan Lawyer Noel Keane — He Delivers," *People* (30 March 1987), 95.

79. *Ibid.*

80. W. Ellsworth-Jones, "Cashing In on the Baby Boom," *Sunday Times* (23 August 1987).

81. As a consequence of his practice, Noel Keane is subject to criticism such as "he's exploiting women; he's selling babies; he's defying the laws of God and nature."

But Keane, a Catholic who attends Divine Child Church with his wife and two sons, contemptuously dismisses his critics. "Who gives a s---? That's my response," he snaps, his reddening face belying his avowed indifference. "Let me show you why I can stand up to all this bulls---." He reaches for a fat three-ring binder entitled "Dear Uncle Noel," which contains correspondence from satisfied clients. There are letters with pictures of babies splashing in wading pools and babies tossing food from their high chairs ("Next time could you give us one with manners!")... (*Kunen, supra*, note 79.)

The practices of Mr. Keane are described more fully in the subsection "Brokers" of "The Effect of Third Parties' Interests and Activities" in Part 3.

82. Ellsworth-Jones, *supra*, note 80.

83. Gladwell and Sharpe, *supra*, note 36, 18.

84. M. Schwed, "Surrogate Mothers of Invention," *Los Angeles Herald Examiner* (23 May 1988): B1.

85. *Ibid.*

86. *Ibid.*

87. *Ibid.* Bill Handel's practices are described more fully in the subsection "Brokers" of "The Effect of Third Parties' Interests and Activities" in Part 3.

88. Testimony of Richard Levin before U.S. Congress, House, Committee on Energy and Commerce, Subcommittee on Transportation, Tourism and Hazardous Materials, *Hearing on a Bill to Prohibit Certain Arrangements Commonly Called Surrogate Motherhood and for Other Purposes*, 100th Cong., 15 October 1987, Serial No. 100-143 (Washington, DC: U.S. Government Printing Office, 1988), 113.

89. Neustatter, *supra*, note 8.

90. *Ibid.*

91. Kent, *supra*, note 22. See also Ballantyne, *supra*, note 22.

92. Kent, *supra*, note 22.

93. *Ibid.*

94. *Ibid.*

95. J.L. Yovich and T.D. Hoffman, "IVF Surrogacy and Absent Uterus Syndromes," *Lancet* (6 August 1988): 331-32.

96. E. Levin, "Motherly Love Works a Miracle," *People* (19 October 1987): 39.

Notes to Part 2

1. In Quebec, a civil law jurisdiction, the legislature has made amendments to the Civil Code that would render preconception arrangements unenforceable. *Quebec Civil Code*, S.Q. 1991, c. 64, assented to 18 December 1991. [Editor's note: At the time of writing, this bill had not been proclaimed in force, but enabling legislation had been assented to on 18 December 1992; the Act came into force on 1 January 1994.]
2. K.M. Brophy, "A Surrogate Mother Contract to Bear a Child," *Journal of Family Law* 20 (1981-82): 263-91 [hereinafter Brophy Agreement]; the "Surrogate Parenting Agreement," available upon request to Noel Keane, 930 Mason, Dearborn, Michigan 48124, U.S.A. [hereinafter Keane Agreement]; and Appendices A and B of *In the Matter of Baby "M"*, 537 A. 2d 1227 (N.J. Sup. Ct. 1988) at 1265-1273 [hereinafter Baby M Agreement].
3. Brophy Agreement, paragraph III; Baby M Agreement, paragraphs 2 and 3; Keane Agreement, paragraphs 1 and 11, *supra*, note 2.
4. Brophy Agreement, paragraphs II and III; Baby M Agreement, paragraphs 2 and 3; Keane Agreement, paragraph 10, *supra*, note 2.
5. Brophy Agreement, paragraph XIII, *supra*, note 2.
6. Baby M Agreement, paragraph 9; Keane Agreement, paragraph 12, *supra*, note 2.
7. Keane Agreement, paragraph 12; Brophy Agreement, paragraph XXII, *supra*, note 2. Brophy's provision assumes that the commissioning man might not be married and therefore simply enables him to fill in a blank with the name of a person to whom the carrying woman must give the child should the commissioning man be dead.
8. Brophy Agreement, paragraph V; Baby M Agreement, paragraph 4; Keane Agreement, paragraph 15, *supra*, note 2. This paragraph in the Keane Agreement states, "the consideration for this Agreement, which is compensation for services and expenses, [is] in no way ... to be construed as a fee for termination of parental rights."
9. Baby M Agreement, paragraph 10. In the Brophy Agreement, paragraph XI, the commissioning man similarly pays the carrying woman nothing if she miscarries prior to the fifth month and pays a non-specified sum if there is a subsequent miscarriage or stillbirth. The Keane Agreement, paragraph 16, presumably to avoid the charge of baby selling, states that the carrying woman will be paid a sum prorated to the number of days she was pregnant, *supra*, note 2.
10. Baby M Agreement, paragraph 13; Keane Agreement, paragraph 9, *supra*, note 2. Brophy does not mention amniocentesis.
11. Baby M Agreement, paragraph 13, *supra*, note 2. The Keane Agreement, paragraph 9 (doubtless in response to the Baby M decisions, which held that the abortion clause was void), states that the commissioning man may not require the carrying woman to have an abortion.
12. Brophy Agreement, paragraph I; Baby M Agreement, paragraph 1; Keane Agreement, paragraph 11, *supra*, note 2.

13. Brophy Agreement, paragraph XXIV; Baby M Agreement, paragraph 15, *supra*, note 2.
14. Keane Agreement, paragraph 8, *supra*, note 2.
15. Brophy Agreement, paragraph V(c)(1); Baby M Agreement, paragraph 4; Keane Agreement, paragraph 15(c), *supra*, note 2.
16. The determination of who would be legally considered as the mother and father of the commissioned child does not decide other significant matters such as custody, access, and child support. The determination of parentage does, however, affect the status of the parties in making such claims. See, for example, the decision of the Ohio Court of Appeal *In re Adoption of Reams*, where the application for the adoption of a commissioned child was sent back to trial for a determination of parentage. Young J. ruled that "Legal parentage, not to be confused with biological parentage, must be established before the issue of custody can properly be decided and is germane in this case to determine the proper parties required to give consent in an adoption proceeding." 557 N.E. 2d 159 (Ohio App. 1989) at 163.
17. Children's Law Reform Act, R.S.O. 1980, c. 68, s. 1(1), as amended.
18. A.E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies," *Yale Law Journal* 96 (1986): 187-208.
19. 286 Cal. Rptr. 369 (Cal. App. 4 Dist. 1991).
20. For further criticism of the court's reasons, see A.M. Capron, "Whose Child Is This?" *Hastings Center Report* 21 (November-December 1991): 37-38.
21. See discussion below in Part 5. "Legislative Proposal: 6. How shall legal maternity be determined?"
22. *Supra*, note 17.
23. Section 8(1) of the CLRA, *supra*, note 17, lists six circumstances that give rise to a presumption of paternity by a person:
 1. The person is married to the mother of the child at the time of the birth of the child.
 2. The person was married to the mother of the child by a marriage that was terminated by death or judgment of nullity within 300 days before the birth of the child or by divorce where the decree nisi was granted within 300 days before the birth of the child.
 3. The person marries the mother of the child after the birth of the child and acknowledges that he is the natural father.
 4. The person was cohabiting with the mother of the child in a relationship of some permanence at the time of the birth of the child or the child was born within 300 days after they ceased to cohabit.
 5. The person has certified the child's birth, as the child's father, under the Vital Statistics Act or a similar act in another jurisdiction in Canada.
 6. The person has been found or recognized in his lifetime by a court of competent jurisdiction in Canada to be the father of the child.
24. *Supra*, note 17, s. 8(1).
25. By "single" is meant that the woman is unmarried and not cohabiting with a male partner in a relationship of some permanence at the time of the birth or within 300 days prior to the child's birth.

26. R.S.O. 1980, c. 524, s. 6(2), as amended.
27. *Supra*, note 17.
28. Section 8(3) of the CLRA, *supra*, note 17, states that, where circumstances give rise to presumptions of paternity by more than one father, no presumption shall be made as to paternity.
29. *Supra*, note 17, ss. 4(1) and 4(2).
30. More precisely, she is married at the time of birth, she was in a marriage that terminated within 300 days of the child's birth, or she married a man after the child's birth who acknowledges that he is the child's natural father. *Supra*, note 17, s. 8(1)1-3.
31. By "cohabiting" is meant that the woman lived with a man in a relationship of some permanence at the time of the child's birth or gave birth within 300 days after they ceased to cohabit. *Supra*, note 17, s. 8(1)4.
32. There are a number of reported cases in the United Kingdom and the United States involving a married carrying woman who was willing to acknowledge the commissioning man as the father. See, for example, *Re C (A Minor) (Wardship: Surrogacy)*, [1985] F.L.R. 846 (U.K. Fam. Div.); *Re an Adoption Application (Surrogacy)*, [1987] 2 All E.R. 826 (U.K. Fam. Div.); *In re Baby Grl*, 9 F.L.R. 2348 (Ky. Cir. Ct., 1983); *In re R.K.S.*, 10 F.L.R. 1383 (D.C. Super. Ct. Fam. Div., 1984); *Syrkowski v. Appleyard*, 333 N.W. 2d 90 (Mich. App., 1983) and 362 N.W. 2d 211 (Mich. 1985); *In the Matter of the Adoption of Baby Grl L.J.*, 505 N.Y.S. 2d 813 (Sur. 1986); *In the Matter of Adoption of Paul*, 550 N.Y.S. 2d 815 (Fam. Ct. 1990); and the facts alleged by plaintiffs in *Sherwyn & Handel v. California State Department of Social Services*, 218 Cal. Rptr. 778 (Cal. App. 2 Dist. 1985).
33. See *Fox v. Dalzell* (1982), 28 R.F.L. (2d) 174 (Ont. Prov. Ct. Fam. Div.), which held that the presumption of paternity may be rebutted by evidence of blood tests to the contrary.
34. CLRA, *supra*, note 17, s. 8(1)5.
35. *Ibid.*, ss. 8(1)1-4.
36. *Ibid.*, s. 8(3).
37. *Ibid.*, ss. 4(1) and 4(2).
38. *Mouritsen v. Shepley* (1979), 11 R.F.L. (2d) 285 (Ont. Co. Ct.), court ordered blood tests to establish paternity in action by mother for custody and child support; *H. v. H.* (1979), 9 R.F.L. (2d) 216 (Ont. Supreme Ct., Fam. Div.), in divorce proceedings, court would grant order for blood tests and accept such evidence as determinative of paternity of five children alleged to be of marriage.
39. In only one of these seven cases (*Syrkowski v. Appleyard*, *supra*, note 32) did the commissioning man seek a declaratory order of paternity. In the other cases, paternity was ancillary to adoption or wardship proceedings.
40. *Re C (A Minor) (Wardship: Surrogacy)*, *supra*, note 32; and *Re an Adoption Application (Surrogacy)*, *supra*, note 32.
41. *Supra*, note 32, 847-48.
42. *Supra*, note 32.

43. *In the Matter of the Adoption of Baby Girl L.J.*, *supra*, note 32.
44. *Ibid.*, 815.
45. *Supra*, note 32.
46. Kentucky Revised Statutes, Sec. 199.600.
47. *In re Baby Girl*, *supra*, note 32, 2348.
48. *In re Baby Girl*, *supra*, note 32.
49. *Supra*, note 32.
50. *Ibid.*, 1383.
51. *Supra*, note 32.
52. *Syrkowski v. Appleyard* (1985), *supra*, note 32.
53. *Syrkowski v. Appleyard* (1983), *supra*, note 32, 94.
54. 1956 P.A. 205, M.C.L. Sec. 722.711.
55. *Syrkowski v. Appleyard* (1983), *supra*, note 32, 94.
56. *Syrkowski v. Appleyard* (1985), *supra*, note 32, 213.
57. *Supra*, note 32.
58. Demarest J. could not determine from the evidence whether the carrying woman was married but suspected that she was.
59. 537 A. 2d 1227 (N.J. Sup. Ct. 1988).
60. *Adoption of Paul*, *supra*, note 32, 817.
61. The Vital Statistics Act contemplates that a woman might refuse to acknowledge the father. See *supra*, note 26, ss. 6(3), 6(9), 7(3)4.
62. *Ibid.*, s. 6(9).
63. CLRA, *supra*, note 17, s. 4.
64. *Ibid.*, s. 10.
65. *Supra*, note 38.
66. *Ibid.*, 220. The phrase "ulterior motive" is not further defined. *Quare* whether it would encompass an attempt to give effect to a preconception agreement.
67. *Thrane v. Noyes*, 7 F.L.R. 2351 (1981).
68. *Supra*, note 38.
69. *G. (F.) v. G. (F.)* (1991), 32 R.F.L. (3d) 252.
70. *M. v. W. and R.* (1985), 45 R.F.L. (2d) 337 (B.C.S.C.J), referring to an application denied in that case by Boyle Co. Ct. J., 21 February 1985.
71. Although the agreement might be admitted in evidence as proof that the commissioning man wished to be the natural father, whether the court would find that he is to be regarded as the father would turn on evidence of blood tests. (See text accompanying notes 64-70.) See also the case involving Mr. Malahoff and Mrs. Stiver, where the commissioned child was in fact the son of the carrying woman's husband, Mr. Stiver. It was not the preconception arrangement but the blood test results that determined parentage. L.B. Andrews, *Between Strangers: Surrogate*

Mothers, Expectant Fathers, and Brave New Babies (New York: Harper and Row, 1989), 40-46.

72. As shall become clear, this analysis is sufficient to demonstrate that preconception arrangements are of no legal effect. This is true of those arrangements that involve exclusively gestational women. Therefore, no separate analysis will be undertaken of the situation where maternal status is uncertain.

73. See, generally, A.G. Guest, ed., *Anson's Law of Contract*, 26th ed. (Oxford: Clarendon Press, 1984), 1-7; 21-63.

74. M. Garrison, "Surrogate Parenting: What Should Legislatures Do?" *Family Law Quarterly* 22 (1988): 149-72.

75. *K.K. v. G.L. and B.J.L. (King v. Low)* (1985), 44 R.F.L. (2d) 113 (S.C.C.) at 124 per McIntyre J.

76. *Ibid.*

77. See the subsection "Ancillary Provisions" in this part, below.

78. Brophy Agreement, paragraph III; Baby M Agreement, paragraphs 2 and 3; Keane Agreement, paragraphs 1 and 11, *supra*, note 2.

79. Brophy Agreement, paragraphs III, XXII; Baby M Agreement, paragraphs 2, 3, and 9; Keane Agreement, paragraphs 1, 11, and 12, *supra*, note 2.

80. Brophy Agreement, paragraph V; Baby M Agreement, paragraph 4; Keane Agreement, paragraph 15, *supra*, note 2.

81. This is an implicit rather than written provision in the commercially drafted arrangements considered here. See discussion below under the subsections "Payment for Adoption" and "Adoption by Commissioner(s)."

82. See C. Smart, "Power and the Politics of Child Custody," in *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen (London: Routledge, 1989), 1; S. Boyd, "From Gender Specificity to Gender Neutrality? Ideologies in Canadian Custody Law," in *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen (London: Routledge, 1989), 130-35; and R.H. Mnookin, "Child Custody Adjudication: Judicial Functions in the Face of Indeterminacy," *Law and Contemporary Problems* 39 (1975), 230-49.

83. *Lord St. John v. Lady St. John* (1805), 11 Ves. Jun. 525, 32 E.R. 1192 (Ch.) at 1194.

84. *Vansittart v. Vansittart* (1858), 2 De G. & J. 249, 44 E.R. 984 (C.A. Ch.).

85. *Swift v. Swift* (1865), 34 Beav. 266, 55 E.R. 637 (Rolls) at 639.

86. *R. v. Barnardo* (1889), 23 Q.B.D. 305 (C.A.) and *Humphrys v. Polak and Wife*, [1901] 2 K.B. 385 (C.A.), where Lord Justice Stirling held that, when the law gives mothers rights with respect to their children, it does so "not for the benefit or gratification of the mother, still less as part of her property, but in order to enable her to discharge the duties which the law imposes upon her in respect of the infant, and for its benefit. That being so, it is impossible that ... the mother of the child, should divest herself of those rights in favour of another person" at 389-90. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985), 93.

87. *Lyons v. Blenkin* (1820), Jacob 246, 37 E.R. 842 (Ch.).

88. *Swift v. Swift*, *supra*, note 85.
89. As the Master of the Rolls expressed it in *Swift v. Swift*, "The advantage and benefit of the child is the foundation of both the rule and the exception." *Supra*, note 85, 639.
90. (1882), 1 O.R. 388 (Ch.).
91. *Ibid.*, 404.
92. *Ibid.*, 407.
93. *Chisholm v. Chisholm* (1908), 40 S.C.R. 115.
94. *Ibid.*, 122 per Davies J.
95. *Re Cartlidge and Cartlidge* (1973), 3 O.R. 801.
96. *Reid (Gray) v. Gray* (1976), 29 R.F.L. 63 (B.C.S.C.) at 68.
97. *Ibid.*, 68 per Aikens J.
98. S.O. 1986, c. 4 as amended by S.O. 1986, c. 35 and S.O. 1989, c. 72.
99. *Supra*, note 17.
100. S.C. 1986, c. 4 as amended.
101. FLA, *supra*, note 98, ss. 1(1) and 53(1).
102. *Ibid.*, s. 52(1).
103. *Ibid.*, s. 54.
104. *Ibid.*, ss. 52(1)(c) and 53(1)(c).
105. *Ibid.*, s. 54(c).
106. *Ibid.*, s. 56(1).
107. *Supra*, note 17.
108. *Supra*, note 100.
109. CLRA, *supra*, note 17, s. 24(1); Divorce Act, *supra*, note 100, ss. 16(8) and 17(5).
110. *Supra*, note 17.
111. As is required by *ibid.*, s. 24(2)(a)(ii).
112. *Ibid.*, s. 24(2)(d).
113. *Ibid.*, s. 24(2)(e).
114. *Chisholm v. Chisholm*, *supra*, note 93, 122. This was the basis upon which the Michigan Circuit Court found preconception agreements "void as contrary to public policy" in *Yates v. Keane*, 14 F.L.R. 1160 (1987) at 1161.
115. S.O. 1984, c. 55 as amended.
116. *Ibid.*, Part VII.
117. *Ibid.*, s. 131(3).
118. *Ibid.*, s. 131(8).
119. Because a person may not receive payment for consenting under s. 131(3), the consent given in a paid preconception arrangement is invalid for a second reason,

s. 159(b). This second reason for invalidity will be taken up separately below in the subsection "Payment for Adoption."

120. *Ibid.*, s. 145(4).

121. L.B. Andrews, "Surrogate Motherhood: Should the Adoption Model Apply?" *Children's Legal Rights Journal* 7 (1987): 13-20.

122. *Ibid.*, 18.

123. Andrews, *supra*, note 121.

124. *Ibid.*, 20.

125. *Supra*, note 75.

126. *Ibid.*, 116.

127. It might be argued that, in exclusively gestational agreements, the carrying woman is bound by her consent because she is not the genetic mother. This argument relies, however, on the view that the birth mother should not be considered the legal mother. For reasons developed in Part 5, this report recommends that birth mothers be considered legal mothers irrespective of the origin of the ovum.

128. Brophy Agreement, paragraph V; Baby M Agreement, paragraph 4; Keane Agreement, paragraph 15, *supra*, note 2.

129. It could also be argued that the agreements involve the sale of a baby or at least the mother's rights to her baby. But for the purpose of demonstrating that the agreements violate s. 159 of the CFSA, it is not necessary to address that argument.

130. *Surrogate Parenting Associates v. Commonwealth of Kentucky ex. rel. Armstrong*, 704 S.W. 2d 209 (1986).

131. *Supra*, note 59.

132. *Supra*, note 130.

133. *Ibid.*, 212 per Leibson J.

134. *Ibid.*, 213 per Leibson J.

135. *Ibid.*

136. *Ibid.*, 214.

137. *Ibid.*, 214-15.

138. *Supra*, note 59.

139. *Ibid.*, 1241 per Wilentz J.

140. *Ibid.*, 1242 per Wilentz J.

141. This opinion was followed in the New York case of *Adoption of Paul*, where the court required a sworn statement by the carrying woman before it would accept that no payment for her consent had been made. Demarest J. wrote, "only if Elizabeth will swear under oath before this Court that she has not and will not request, accept or receive the \$10,000 promised to her in exchange for surrender of her child, can this court accept such surrender and terminate her parental rights. Only if she is free of the intimidation inherent in her contractual commitment to give up her child and the inducement of a \$10,000 gain, can Elizabeth's surrender of her parental

rights be truly voluntary and motivated exclusively by Paul's best interests." *Supra*, note 32, 819.

142. SPA v. Armstrong, *supra*, note 130.

143. Baby M, *supra*, note 59.

144. *Supra*, note 115. See, generally, Wilson and Tomlinson, *Children and the Law*, 2d ed. (Toronto: Butterworths, 1986).

145. An adoption may occur with Crown wardship where the child has been found "in need of protection" and has become the subject of a Crown wardship order with no access granted to the parents. CFSA, *supra*, note 115, s. 134(2)(a). By wardship proceedings, the Crown becomes the legal guardian and has the authority to consent to adoption; the parents no longer have any decision-making power. Wilson and Tomlinson, *supra*, note 144, 136.

146. CFSA, *supra*, note 115, s. 135(8).

147. Ibid., s. 135(1).

148. Ibid., s. 176(4)(b).

149. Ibid., s. 140.

150. Ibid., s. 140(1).

151. This route is most advantageous to them because it avoids the legislative requirement of initial state supervision in the form of a society or licensee intermediary who would be required under s. 136 to conduct a home study to assess the suitability of the commissioners as parents and the approval of the placement by a state-appointed director.

152. B.M. Dickens, "Surrogate Motherhood: Legal and Legislative Issues," in *Genetics and the Law III*, ed. A. Milunsky and G.J. Annas (New York: Plenum Press, 1985), 191.

153. Section 135(8) of the CFSA clearly states that the placement of a child with the child's parent or a spouse of the parent enables the parent to avoid the obligation of state supervision before making an adoption application.

154. Because of the unusual nature of a preconception arrangement, the District of Columbia Superior Court, in a step-parent adoption application, ordered a home study of the applicants. *In re R.K.S.*, *supra*, note 32.

155. *Adoption of Baby Girl*, *supra*, note 32; *Re an Adoption Application (Surrogacy)*, *supra*, note 32; and *Re C (A Minor) (Wardship: Surrogacy)*, *supra*, note 32. In the first case, the New York judge stated that the adoption application was in the child's best interests but gave no reasons for his opinion.

156. Baby M (1988), *supra*, note 59; and *Adoption of Paul*, *supra*, note 32, in which the court refused to follow *Adoption of Baby Girl*, *supra*, note 32, and held that the adoption application could not be granted because there was insufficient evidence that no payment had been made for the mother's consent to relinquish the child.

157. See the section "The Significant Provisions of a Preconception Agreement" in this part, above.

158. See *Ciarlariello v. Schacter* (1991), 5 C.C.L.T. (2d) 221 (Ont. C.A.); *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (Ont. C.A.); *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Superior Ct.).

159. *R. v. Morgentaler* (1988), 44 D.L.R. (4th) 385 (S.C.C.).

160. Part I of the Constitution Act, 1982, being Schedule B of the Canada Act 1982 (U.K.) 1982, c. 11.

161. This was the only aspect of the *Baby M* preconception arrangement that the trial court held void and unenforceable. *In the Matter of Baby "M."* 525 A. 2d 1128 (N.J. Super. Ch. 1987).

162. (1989), 62 D.L.R. (4th) 634 at 665 *per curiam*. See also the decision in *Paton v. British Pregnancy Advisory Service Trustees*, [1979] 1 Q.B. 276, which held that a husband has no rights in law or in equity to prevent his wife from having an abortion or to stop doctors from carrying out a lawful abortion.

163. See, generally, "Equitable Remedies," in Guest, *supra*, note 73, 516-23.

Notes to Part 3

1. See, for example, R.A. Posner, "The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood," *Journal of Contemporary Health Law and Policy* 5 (1989), 22; Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985), 91 [hereinafter OLRC]; *In the Matter of Baby "M."* 525 A. 2d 1128 (N.J. Super. Ch. 1987) at 1157-58; A.E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies," *Yale Law Journal* 96 (1986): 187-208; and L.B. Andrews, "Surrogate Motherhood: Should the Adoption Model Apply?" *Children's Legal Rights Journal* 7 (1987): 13-20.

2. See, for example, *Surrogate Parenting Associates, Inc.*, Brochure, Suite 222, Doctors Office Building, 250 East Liberty Street, Louisville, Kentucky 40205, U.S.A.: "Infertility strikes one in every six to seven couples. There exist few families who do not understand the pain and suffering involved in the infertility situation. A true understanding of the problem of infertility would, in SPA's view, lead to feelings of empathy, understanding and tolerance with respect to the surrogate parenting procedure."

3. See, for example, "Infertility: Babies by Contract," *Newsweek* (4 November 1985), 74: "Thwarted by infertility and the endless snares of the adoption process, a growing number of childless couples are resorting to the costly often angst-ridden alternative of surrogate parenting"; *Woman's Own* (11 July 1987), 1: "[S]urrogacy will remain a highly controversial issue. Should a childless and infertile couple be allowed to have a child through a surrogate mother?"

4. See, for example, "ABC Nightline," 6 December 1983, Show #672, 2: "[S]o far more than 100 couples in America have used [surrogate motherhood] to solve a problem that affects one out of five couples today: infertility." Joanne Ramirez: "Unless you've ever been in the position where you are infertile or having a difficult time ... having a child, people just don't understand the agony that people go through who want a child and a family lifestyle ... I want to go to the zoo with the toddler, and so does Michael. And so people will go to any lengths to do that, and we think ours is one of the more reasonable ways to do it." See also CBS News, "West 57th," 11 March 1989, Show #163, 2: "When Julie Bouldry gave birth to healthy twins ... [she] left the delivery room with \$10,000 for a downpayment on a

house. And Steve and Susan Fitler, a childless couple from Oklahoma, left with Alexandra and Stephanie, two children they had been unable to bear on their own."

5. See, for example, American Bar Association, Section of Family Law, "Draft ABA Model Surrogacy Act," *Family Law Quarterly* 22 (1988), 125, section 1.

6. See, for example, OLRC, *supra*, note 1, 14-17, 232; and New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (Albany: 1988), chap. 1.

7. See, for example, P.H. Schuck, "The Social Utility of Surrogacy," *Harvard Journal of Law & Public Policy* 13 (1990): 132-38; M. Freeman, "Is Surrogacy Exploitative?" in *Legal Issues in Human Reproduction*, ed. S. McLean (Aldershot: Gower, 1989); A.M. Capron, "Alternative Birth Technologies: Legal Challenges," *U.C. Davis Law Review* 20 (1987): 679-704; and M.R. Mellown, "An Incomplete Picture: The Debate About Surrogate Motherhood," *Harvard Women's Law Journal* 8 (1985): 231-46.

8. See, for example, E.C. Wood and P. Singer, "Whither Surrogacy?" *Medical Journal of Australia* 149 (1988), 426: "The problem of infertility cannot be met fully by the new medical technology, such as in-vitro fertilization and ovulation induction, or by the adoption of healthy infants, who have become scarce."

9. See, for example, L.B. Andrews, "When Should You Use a Surrogate Mother," in *New Conceptions: A Consumer's Guide to the Newest Infertility Treatment Including In Vitro Fertilization, Artificial Insemination, and Surrogate Motherhood* (New York: St. Martin's Press, 1984); and D.M. Bartels, "Surrogacy Arrangements: An Overview," in *Beyond Baby M*, ed. D. Bartels et al. (Clifton: Humana Press, 1989).

10. Less often, a variation of this picture is presented by people wishing to justify the practice. Some proponents stress that what is desired is the commissioning man's genetically related child, and base their arguments on their view that this fact is sufficient justification. This less common picture of demand is discussed further in the subsection "A More Complete Description of Commissioners' Desires" in this part, below.

11. See, for example, L.B. Andrews, *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies* (New York: Harper and Row, 1989); N. Keane with D. Breo, *The Surrogate Mother* (New York: Everest House, 1981), 57 *et seq.*; "Many Eager to Be Surrogates," *Calgary Herald* (18 February 1988): C4.

12. See, for example, P. Adair, *A Surrogate Mother's Story* (Toronto: Paperjacks, 1988); K. Stevens with E. Dally, *Surrogate Mother: One Woman's Story* (London: Century, 1985).

13. OLRC, *supra*, note 1, 72.

14. Indeed, when the majority of the Advisory Panel to the California State Legislature Joint Committee on Surrogate Parenting presented its report, it lamented the paucity of credible research. Professor Vicki Michel presented the majority's report stating, "We need very much, some objective research on surrogacy ... A letter that recruited subjects for [a study] ... called 'Surrogate Mothers — The Relationship Between Early Attachment and the Relinquishing of a Child'... a doctoral dissertation by Rita Resnick, [read] ...

I would very much like to have your participation in my study. My aim is to gain further understanding of the surrogate mother population to

hopefully help surrogate programs continue in the future.

And then later she says:

Thank you so much for your help. It is people like you who make innovative programs possible. I hope I can help secure the future of surrogate mothering programs.

The statement of the values and orientation of the researcher cannot help but bias the study ... So I think that we have to recognize that we are operating in ... a vacuum of data." California, Joint Legislative Committee on Surrogate Parenting, "Majority Report to the California Legislature," in *Commercial and Non-Commercial Surrogate Parenting* (Sacramento: Joint Publications Office, 1990), 13-14.

15. It will be recalled from the news stories at the time that the commissioning woman in that case, Betsy Stern, was not clearly infertile, nor did she and her husband attempt to have a child themselves or to adopt. Moreover, the carrying woman, Mary Beth Whitehead, appeared to be willing to participate in the agreement but, according to the psychologist whom she saw prior to conception, she was unlikely to be able to relinquish her child at birth. In addition, the effects of the agreement were felt by more than the principal parties. Mary Beth Whitehead's other children suffered from losing their half-sibling and her marriage ended in divorce. "Whose Child Is This? Baby M and the Agonizing Dilemma of Surrogate Motherhood," *Time* (19 January 1987): 61; "Surrogate Seemed 'Perfect,' Father of Baby M Testifies," *New York Times* (6 January 1987): B1; R. Arditti, "The Surrogacy Business," *Social Policy* 18 (1987): 42-46; P. Chesler, *Sacred Bond: The Legacy of Baby M* (New York: Times Books, 1988); and "Surrogate Mother, Husband Split-Up, Stress of Baby M Custody Case Blamed for Failure of Marriage," *Toronto Star* (5 August 1987): B11. Mary Beth Whitehead subsequently remarried and gave birth to two more children.

16. Brokers moved quickly, even before the *Baby M* case went to trial and after the appellate court decision, to control the damage to the carefully crafted image they had created that their arrangements work. Two newspaper articles photocopied by and available from the Center for Surrogate Parenting, Beverly Hills, California, suggest that Mary Beth Whitehead was atypical: "Surrogate Mothers: Not All Regret or Renegue on Delicate Pact," *San Diego Tribune* (26 December 1986); "Surrogate Mothers of Invention: Unlike Baby M, Most Cases End Happily," *Los Angeles Herald Examiner* (23 May 1988).

17. W. Ellsworth-Jones, "Cashing In on the Baby Boom," *Sunday Times* (23 August 1987): 33.

18. Interview with Patricia Foster, "Shirley," CTV, 1 February 1991. Patricia Foster is currently attempting to regain custody of her son; "Appendix 10, Case Description of 'Conflicts in Commercialized Childbearing' by the National Coalition Against Surrogacy," in M. Eichler and P. Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians*, a report prepared for the Law Reform Commission of Canada (Toronto: Ontario Institute for Studies in Education, 1988).

19. *Baby M*, *supra*, note 1, 1139.

20. "Infertility: Babies by Contract," *supra*, note 3.

21. *Ibid.*

22. Foster, *supra*, note 18.

23. Keane and Breo, *supra*, note 11.
24. See, for example, S.M. Hall, "Surrogate Mother Elizabeth Kane Delivers Her 'Gift of Love' — Then Kisses Her Baby Goodbye," *People* (10 December 1980): 52-54; E. Markouksas, "Women Who Have Babies for Other Women," *Reader's Digest* 119 (August 1981): 77.
25. Quoted in G. Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* (New York: Harper and Row, 1985), 223.
26. *Ibid.*
27. *Ibid.*, 223-24.
28. K. Dunn, "Dilemma of Seeking a Surrogate Mother," *Montreal Gazette* (13 January 1990): K1.
29. *Ibid.*
30. R. Lacayo, "In the Best Interests of a Child," *Time* (13 April 1987): 50.
31. Andrews, *supra*, note 11, 43.
32. See the subsection "A More Complete Description of Commissioners' Desires" in this part, below.
33. M. Campbell, "Surrogate Named Baby's Legal Mother: Couple's Breakup Prompted Battle for Child," *Globe and Mail* (19 April 1991): A1. The carrying woman had learned of the marital discord only when the commissioning woman told her, a day before she gave birth. The carrying woman had then agreed to give up her child on the condition that the adoption not occur for at least a year and the Moschettas undergo marriage counselling, among other provisions. M. Lait, "Judge Orders Co-Custody in Surrogate Case," *Los Angeles Times* (27 September 1991): A3.
34. T. Lewin, "A Custody Case with Extra Tangles," *New York Times* (26 January 1989): A12.
35. "Social Studies," *Globe and Mail* (14 May 1992): A18.
36. Keane and Breo, *supra*, note 11, 171. Keane claims to have invited Joseph in for a consultation. Joseph assured Keane that his life would be structured to care for a newborn but it would not be appealing to a wife. "Maybe I'm selfish right now and simply do not want to share my son with anybody else. I realize it would be easy to put down my motives. To say I'm being narcissistic. But that isn't the way I work. Music, the theatre, and sports are my passions. I have a \$50,000 stereo setup, not because it costs that much but because I wanted the best in music. I drive an old car and wear old clothes. The hair transplant is for professional reasons. Why should I look thirty-five when I am thirty? I go all out for the things I care for. That's why my stereo system is the best money can buy. I love to listen to good music. And I get up many mornings at four A.M. to play the piano. What kind of woman is going to want to put up with that?" (*Ibid.*) Keane does not discuss whether his client's schedule would alter with the arrival of a newborn.
37. Quoted in Corea, *supra*, note 25, 217. Handel's firm takes only infertile married couples as commissioning couples. But he is not morally opposed "to using surrogates for gay men. Two such men, physicians with high incomes in a stable relationship, asked him to arrange a birth for them. He declined. He is trying to get some favourable legislation on surrogate motherhood passed ... so he runs his

business conservatively. ‘I told them it was a *political choice* I was making not to take them on. Chances are that the two of them would have made phenomenal parents,’” (*ibid.*, 218).

Noel Keane is also in favour of enabling any man to be a commissioner. “Frankly I don’t have a problem with homosexuals … There was a couple … super nice guys. I liked them but my support group and the office staff and my wife didn’t think it would be a good idea. They are always talking in the abstract rather than about individuals. I’m the individualist, but we chose not to get into it in any case.” D. Frank and M. Vogel, *The Baby Makers* (New York: Carroll and Graf, 1988), 214.

38. See, for example, “This Week’s Child,” a weekly column appearing on Wednesdays in the *Toronto Star*.

39. Corea, *supra*, note 25, 218.

40. *Ibid.*

41. K.M. Brophy, “A Surrogate Mother Contract to Bear a Child,” *Journal of Family Law* 20 (1981-82): 263-91 [hereinafter Brophy Agreement], paragraph XXI; the “Surrogate Parenting Agreement,” available upon request to Noel Keane, 930 Mason, Dearborn, Michigan 48124, U.S.A. [hereinafter Keane Agreement], paragraph 11.

42. In the Brophy Agreement, published in 1981, the carrying woman specifically agrees to an abortion should the fetus she carries be determined to be “physiologically abnormal” (paragraph XX). In the Keane Agreement, the carrying woman agrees “to undergo amniocentesis … or similar tests to detect genetic and congenital defects” but acknowledges that the decision to abort is her decision (paragraph 9).

43. The harmful effects of undergoing amniocentesis and an abortion in the second trimester are not averted to in the agreements but are documented by B.K. Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (New York: Viking Penguin, 1986).

44. “If the social parents do not wish to accept custody of the child, they cannot be compelled to do so as a matter of law or as a practical matter, and the children’s aid society will undoubtedly intervene.” OLRC, *supra*, note 1, 255.

45. Andrews, *supra*, note 11, 43.

46. Richard Levin speaking on the television show “Donahue,” 15 April 1980, Transcript #04150, 12.

47. Brophy Agreement, paragraphs V(c)(3) and VI; Keane Agreement, paragraph 15(c)(3).

48. *Supra*, note 5, 139. This proposal is discussed more fully below in Part 4.

49. OLRC, *supra*, note 1, 245. Interestingly, the report suggested that the commissioning man would be curious about paternity only if there were a genetic defect, whereas the commissioning woman would want to know simply because she would not want to raise anyone else’s child but his: “The biological paternity of the child may be contested by a prospective social father if the child is found to be affected by a genetic defect, or if his wife wants assurance that it is his child whom she is to be legally responsible for rearing” (*ibid.*). The OLRC arguments are analyzed below in the subsection “The Argument of Medical Necessity” of “A Consideration of Proponents’ Arguments” in Part 4 and in Appendix 2.

50. S. Edmiston, "Whose Child Is This?" *Glamour* 89 (November 1991): 235 *et seq.*
51. D. Poff, "Content, Intent and Consequences: Life Production and Reproductive Technology," *Atlantis* 13 (1988), 114.
52. *Ibid.*
53. Foster, *supra*, note 18; and Keane and Breo, *supra*, note 11, 158.
54. P. Nowakowski, "How Could I Let Them Separate My Twins?" *Redbook* (July 1990), 38.
55. *Ibid.*, 41.
56. See, for example, a brochure available from Keane's Infertility Center of New York entitled, "More About Surrogates."
57. Frank and Vogel, *supra*, note 37, 184.
58. Hilary Hanafin quoted in Andrews, *supra*, note 11, 68.
59. See, for example, L. Arking, "Searching for a Very Special Woman," *McCall's* (June 1987), 55.
60. J.N. Lasker and S. Borg, *In Search of Parenthood: Coping with Infertility and High-Tech Conception* (Boston: Beacon Press, 1987), 75.
61. "Surrogate Parenting Center Sets Stringent Selection Criteria: RNs Ideal Candidates," *Nurses Week* (5 February 1990).
62. Foster, *supra*, note 18.
63. *Ibid.*
64. E. Kane, "Surrogate Parenting: A Division of Families, Not a Creation," *Reproductive and Genetic Engineering* 2 (1989), 107.
65. *Ibid.*, 108.
66. Hilary Hanafin quoted in Andrews, *supra*, note 11, 68, 70, and 71.
67. Arking, *supra*, note 59, 55.
68. J.G. Raymond, "Reproductive Gifts and Gift Giving: The Altruistic Woman," *Hastings Center Report* 20 (November-December 1990), 8.
69. J.S. Kunen, "Childless Couples Seeking Surrogate Mothers Call Michigan Lawyer Noel Keane — He Delivers," *People* (30 March 1987), 97.
70. "This Week with David Brinkley," 5 April 1987, Transcript #284, 7.
71. N. Brozan, "Surrogate Mothers: Problems and Goals," *New York Times* (27 February 1984): C12.
72. "Mother's Little Helper," *New York Times* (10 March 1980), 10.
73. Brozan, *supra*, note 71.
74. Hilary Hanafin quoted in Edmiston, *supra*, note 50, 276.
75. "ABC Nightline," 5 February 1987, Transcript #1488, 4.
76. Andrews, *supra*, note 11, 240.
77. Noel Keane, "Happy Surrogate Moms — A Rebuttal," "Geraldo," 29 September 1987, Show #7, 5.

78. Kane, *supra*, note 64, 108.
79. Keane and Breo, *supra*, note 11, 138-39.
80. *Ibid.*, 139.
81. Consider the case of Diane Downs who was a carrying woman for Richard Levin's brokerage house, a case that brokers do not bring to public attention. Downs saw Levin on the television show "Donahue," and decided to carry a child for the \$10 000. A victim of repeated rape by her father, Downs was evaluated for Levin by a Kentucky psychiatrist who said of her, "There is considerable neurotic interplay, both in [Downs'] marriage and in [her] total adjustment to life." The report was unfavourable so Levin sought a second evaluation. "Diane was examined by a Phoenix psychiatrist at the request of the Louisville clinic ... Diane was accepted into the surrogate program." She enjoyed the pregnancy though she "craved attention" and was accused by her neighbours of neglecting her other three children (p. 134). When she gave birth on 7 May 1982, she "seemed to have no trace of postpartum depression, no grief over giving up her child. She felt only joy and such a sense of well being." She relinquished her child on 12 May 1982. Almost exactly one year later, on 19 May 1983, she took her other three children, aged 8, 7, and 3, for a drive in the country and, one by one, she shot them. In June of 1984, she was convicted of murder and two counts of attempted murder. A. Rule, *Small Sacrifices* (New York: Signet, 1988), 21-30, 121, 126, 128-29, 132, 140, 436.
82. See G. Corea, "Junk Liberty," Appendix G in *Surrogate Motherhood: Politics and Privacy*, ed. L. Gostin (Bloomington: Indiana University Press, 1990), where she discredits the view that the lack of protest by carrying women when they relinquish the children and afterwards entails that they are "happy."
83. Andrews, *supra*, note 11, 252. See also Frank and Vogel, *supra*, note 37, 155-94; Lasker and Borg, *supra*, note 60, 72-91; "Surrogate Mother Extols 'Joy of Life' in Novel Experience," *Los Angeles Times* (1 January 1987).
84. Alejandra Munoz, a 21-year-old Mexican woman with a grade two education, was allegedly brought to the United States illegally by her second cousins on the understanding that she would conceive a child for them by artificial insemination and that the embryo would be flushed from her and transferred to the uterus of her cousin, Nattie Haro. But once pregnant, Munoz claims that Haro told her the transfer could not be performed at all, and that she was kept in her cousin's house throughout the pregnancy, forbidden even to go for a walk. Apparently Haro wished her friends and neighbours to believe the child was hers and wore a small pillow under maternity clothes. Munoz was registered in the name of "Nattie Haro" both with the doctor and at the hospital where she gave birth by Caesarian section. Unable to read English, Munoz did not know that the birth certificate recorded Nattie Haro as the mother. To fight for her child, Munoz was hampered by her need to recover from surgery, by her ignorance of both the English language and the American judicial process, by her status as an illegal alien, and by her poverty. Nevertheless, the case was heard three and one-half months after the girl's birth and the judgment permitted Munoz to see her child several days a week and to receive from the Haros \$50 a month in child support. The Haros had earlier offered her \$1 500 as a fee for carrying the child but Munoz refused. Testimony of Gene Corea and Alejandra Munoz before U.S. Congress, House, Committee on Energy and

Commerce, Subcommittee on Transportation, Tourism and Hazardous Materials, *Hearing on a Bill to Prohibit Certain Arrangements Commonly Called Surrogate Motherhood and for Other Purposes*, 100th Cong., 15 October 1987, Serial No. 100-143 (Washington, DC: U.S. Government Printing Office, 1988), 24 and 37; "A Split Decision," *Time* (9 March 1987).

85. "The Oprah Winfrey Show," WLS-TV, 19 February 1988, Transcript #W375.
86. H.A. Leal, "Vice Chairman's Dissent," OLRC, *supra*, note 1, 290.
87. *Ibid.*
88. "100 Questions to a Woman Who Rented Her Uterus," *Emanuelle*, translated by Rita Arditti and appearing in "Surrogacy in Argentina," *Issues in Reproductive and Genetic Engineering* 3 (1990), 35-43.
89. When Amelia was pregnant, however, she decided to keep the child and told the physician, her employer, of her decision:

Amelia: ... He got very angry and started screaming, he said that they would take the money back [which had been paid in advance of delivery] and on top of that, they would leave me without work, that they were going to fire me. I started to cry and afterwards he told me that the thing could be fixed ... that if I was not stubborn they would let me keep the money and they would raise a bit my salary in the clinic. (*Ibid.*, 39)

90. Quoted in Frank and Vogel, *supra*, note 37, 181. Similarly, Hanafin of the Center for Surrogate Parenting claims, "It seems bad politics to accept women who are in dire need of financial assistance, and for women on welfare, the case could be made that they are doing it purely for the money." *Ibid.*
91. See, especially, Andrews, *supra*, note 11; Lasker and Borg, *supra*, note 60, 72-91 and 105-21; Frank and Vogel, *supra*, note 37.
92. Andrews, *supra*, note 11, 33.
93. E.C. Sandberg, "Only an Attitude Away: The Potential of Reproductive Surrogacy," *American Journal of Obstetrics and Gynecology* 160 (1989), 1445.
94. Frank and Vogel, *supra*, note 37, 182; see also Andrews, *supra*, note 11, 257 and 260.
95. Keane and Breo, *supra*, note 11, 236.
96. Elchler and Poole, *supra*, note 18. See the subsection "Commissioners" of "Participants in Preconception Arrangements" in Part 1.
97. R. Arditti, *supra*, note 15, 44.
98. E. Tesher, "'It Was Just a Job,' Surrogate Mother Tells Star," *Toronto Star* (21 August 1982): A1.
99. A.Z. Overvold, *Surrogate Parenting* (New York: Pharos Books, 1989), 121-22.
100. *Ibid.*
101. *Re P (Minors) (Wardship: Surrogacy)*, [1987] 2 F.L.R. 421. Sir John Arnold gave judgment in her favour when she refused to relinquish the twins.
102. *Ibid.*, 426.
103. Quoted in Corea, *supra*, note 25, 229.

104. See P.J. Parker, "Surrogate Motherhood, Psychiatric Screening and Informed Consent, Baby Selling, and Public Policy," *Bulletin of the American Academy of Psychiatry and the Law* 12 (1984): 21-39.

105. P.J. Parker, "Motivation of Surrogate Mothers: Initial Findings," *American Journal of Psychiatry* 140 (1983): 117-18.

106. P.J. Parker, "The Psychology of the Surrogate Mother: A Newly Updated Report of a Longitudinal Pilot Study," paper presented at the American Orthopsychiatric Association General Meeting, Toronto, 9 April 1984. In this study, Parker found that 93 percent of the women accepted a \$10 000 lump sum fee plus expenses. According to Parker, all but one carrying woman viewed the fee as a payment for services and not as a fee for parental rights and responsibilities. Apparently, the promise of payment was an important factor in initiating participation in the preconception arrangement. Further, as discussed below, Parker found that the money became less significant as the fetus developed and that many women felt ambivalent about accepting it (*ibid.*, 7).

107. This vulnerability is obvious in the following example of a single woman who had a difficult pregnancy pursuant to a preconception arrangement and yet was willing to initiate a second one to regain the attention she received from the brokers' staff whom she apparently idealized:

The pregnancy made me feel sick as a dog. I've never been so sick in my life. I was going through a great deal of emotional problems and admitted myself to a hospital to get some rest. I had to place my children in foster homes for the rest of the pregnancy.

The pregnancy kept me going through all that, and also my relationship with the program. I would trust those guys with my life. They really care about me, they tell me I'm their star. They're my knights in shining armor; they've helped me through a lot. Even though I'm having a hard time getting pregnant again, I'll keep trying for them. (Lasker and Borg, *supra*, note 60, 117)

108. Keane and Breo, *supra*, note 11, 177-78.

109. Edmiston, *supra*, note 50, 275.

110. An English carrying woman described her unhappiness:

It was all very well for me to be detached from the baby, but I was fed up with Robert and Jean's detachment from me. In those early months, they hardly ever rang me up as they used to, and that really upset me ...

"I'm disappointed in this whole thing," I told him.

"Disappointed in what sense?" he asked. He sounded a little alarmed.

"Well, it's just not what I expected. I thought we were going to be good friends while this was happening, that we were going to share the pregnancy and everything else. And now I feel as if the relationship is growing colder instead of warmer. This isn't what I wanted, and it's worrying me."

Robert didn't agree.

... After that, I decided not to press the issue ... I think that this was when I realised I might not get what I had wanted from surrogate motherhood in the first place. (Stevens with Dally, *supra*, note 11, 72)

111. One commissioner described the relationship between the carrying woman and his wife and himself on "ABC Nightline":

Randy: She is very positive towards carrying our child and knows that this child belongs to Randy and his wife. Her own daughter feels that way about it, and her daughter, by the way, is fairly young.

Koppel: How long has your wife been down there caring for the other children with her?

Randy: She's been down there about two weeks now.

Koppel: So I assume there's a friendly, perhaps even close relationship between the two women?

Randy: Very friendly. We have talked with our surrogate mother now at least once a week, sometimes more often, as we both deemed necessary, and this has been going on for over a year now ... we also have an agreement between ourselves, an understanding, and she is the one that requested that we not contact her, and that she not contact us. She realizes when she says goodbye to the baby and kisses the baby goodbye, that is it. She is going to continue on with her life and we're going to continue on with our life ... ("Surrogate Motherhood," "ABC Nightline," *supra*, note 75, 6)

112. "Donahue," Transcript #03127, 1987, 2.

113. Lasker and Borg, *supra*, note 60, 117.

114. *Re P (Mnors)*, *supra*, note 101, 424.

115. The mother of Denise Mounce, a carrying woman who died when she was eight months pregnant, appeared on television:

Sally: ... she died and the baby died?

Mrs. Mounce: Yes.

Sally: What happened at the funeral?

Mrs. Mounce: Denise — we never heard from the broker, the doctor, the — nobody the adopting couple, nobody. Nobody sent flowers, no cards, no phone calls, and nobody asked to have that baby to bury it. Grandma, who's ignored, who's neglected, who's not ... considered in a surrogacy parenthood program — the program shattered her, the doctor shattered her, the adopting couple shattered her, and Grandma was left to pick up the pieces, bring them home together and bury them together ...

Dr. Betsy Aigen, Director, Surrogate Mother Program of New York: You know, in the surrogate program that I run, this would never have happened. Your daughter went to a very unreputable program.

Mrs. Mounce: I don't believe that. I believe that it could happen to any baby broker, because they do it for the money. ("Should Women Rent Wombs?" "Sally Jessy Raphael," 3 January 1989, Transcript #87, 3-4)

116. Parker, *supra*, note 106, 6-7.

117. *Ibid.*, 4.

118. *Ibid.*, 7.

119. *Supra*, note 3.

120. "A Surrogate's Story of Loving and Losing," *U.S. News and World Report* 94 (6 June 1983): 77.

121. "A Woman Today: Giving the Gift of Life," *Ladies' Home Journal* (February 1989), 22 and 28.

122. *Ibid.*, 22.

123. Parker, *supra*, note 106, 12.

124. Phyllis Chesler argues that there is another form of harmful past experience, incest, that might make a woman vulnerable to a wish to participate in a preconception arrangement:

Phyllis: What happened once it was clear that Frank and Dawn weren't going to let you have a relationship with them or with Jason?

Sally: I got very blue. I started seeing a psychiatrist. She got me to thinking about how my body had been used by men over many years, and I never had anything to say about it. Because I was a victim of incest. My father had incest with me for six years, since I was eight years old.

Phyllis: Would you say that deciding to be a "surrogate" is related to being an incest victim?

Sally: Definitely. I hadn't reckoned how to cleanse my soul. How do I get my father's semen out of my body? I could accomplish this in the surrogate process. I could offer my body. This time, I was the one offering. Freely. This would somehow cleanse my soul.

It is not known how many women who have acted as carrying mothers are, in fact, victims of incest. Chesler, *supra*, note 15, 66.

125. Interestingly, in 1982 Philip Parker identified this motivation as the desire "to give the gift of a baby to a parent who needed a child." Two years later he describes the same desire to give "the gift of a baby to an infertile couple." Parker, *supra*, notes 105 and 106.

126. Frank and Vogel, *supra*, note 37, 184.

127. R. Christopher, "A Judgment for Solomon," *Maclean's* 94 (6 April 1981), 33.

128. Foster, *supra*, note 18.

129. Parker, *supra*, note 106.

130. *Woman's Own*, *supra*, note 3.

131. Parker, *supra*, note 106, 6.

132. *Ibid.*

133. Overvold, *supra*, note 99, 122.

134. *Ibid.*

135. I. Peterson, "Surrogate Mothers Vent Feelings of Doubt and Joy," *New York Times* (2 March 1987), B4.
136. Lasker and Borg, *supra*, note 60, 79.
137. R. Hanley, "Surrogate Mother Tells of Desire to Keep Baby," *New York Times* (9 January 1987): B3.
138. *Supra*, note 1, 72.
139. Parker, *supra*, note 106, 12.
140. *Re P (Minors)*, *supra*, note 101. The letter was written when she thought she would relinquish the children.
141. See text accompanying notes 45 and 54.
142. *Supra*, note 59, 56.
143. "My office is paid \$11 000, and that is a one time fee, and I work with the couple until they have a child no matter how long it takes." Noel Keane on "West 57th," *supra*, note 4.
144. "What Does It Cost? ... \$16 600 for complete coordination and administration of each case, including legal fees, as more fully described on page 2 herein. It also includes psychological screening, counselling and monitoring, as well as approximately \$3 000 for advertising expenses related to finding a suitable surrogate mother." Brochure available from Surrogate Parenting Center.
145. Like most agencies, Keane's primary focus is on the commissioners, since their resources fund the whole operation, and the agreements they sign "are drawn up pretty darn well to represent the couple's interests." Frank and Vogel, *supra*, note 37, 206.
146. *Woman's Own*, *supra*, note 3.
147. Kunen, *supra*, note 69, 93.
148. Keane's brochure explains how he and his wife suffered from secondary infertility. "Although wife Kathy eventually became pregnant, the experience gave him both insight and sympathy for childless couples." *Alternatives for Childless Couples*, promotional brochure available upon request. Similarly, Levin's brochure states:

Infertility strikes one in every six to seven couples. There exist few families who do not understand the pain and suffering involved in the infertility situation. A true understanding of the problem of infertility would, in SPA's view, lead to feelings of empathy, understanding and tolerance with respect to the surrogate parenting procedure. (*Surrogate Parenting Associates Inc., Brochure*, *supra*, note 2)
149. See, for example, the application forms available from Levin's Surrogate Parenting Associates and Handel's Center for Surrogate Parenting.
150. Keane speaking on "ABC Nightline," *supra*, note 75, 5.
151. G. Kopecky, "Wombs for Hire," *Omni* 5 (June 1988), 18.
152. Ibid.
153. *Supra*, note 143, 4-5.

154. *More About Surrogate Mothers*, promotional brochure from Keane's Infertility Center of New York, 14 East 60th Street, Suite 1204, New York 10022, U.S.A.

155. *Surrogate Mother Program*, Center for Surrogate Parenting Inc., 8383 Wilshire Blvd., Suite 750, Beverly Hills, California 90211, U.S.A.

156. In the Mary Beth Whitehead case, the psychologist, Joan Einvohner, said in her written report that Mary Beth "expects to have strong feelings about giving up the baby at the end." But Keane did not refuse to make the arrangement between Mary Beth Whitehead and Bill Stern. Keane is criticized also for encouraging women to become pregnant almost as soon as they inquire, without considering the physical health of the women. An article in *New Republic* describes one carrying woman's experience in Keane's firm:

A 25-year-old woman from Michigan who is suing Keane under the pseudonym Jane Doe says that when she first came to his office, she wasn't convinced she wanted to [enter a preconception arrangement]. She says Keane took her to a room where a childless couple was sitting. For an hour and a half, Doe talked with the couple, while holding her six-month-old son. "They looked like they hadn't eaten in six months and my baby was a hot fudge sundae," Doe says. She put aside her own doubts about her physical and mental readiness and, after several phone calls from the childless couple, decided to [enter into a preconception arrangement].

A review of Jane Doe's medical history would have shown that she recently had an operation for cervical cancer. After the operation, Doe says her doctors warned her not to get pregnant for at least two years. At the age of 25, she had also had five miscarriages out of nine previous pregnancies. What did the doctor working for Keane say about that? According to Doe: "Good, you're really fertile."

Doe endured what can only be described as a harrowing pregnancy. When artificial insemination was scheduled to begin, Doe wasn't fertile because she was still nursing her son. She says Keane's doctors gave her drugs to induce ovulation. Once pregnant, Doe says she had to go to the hospital five times and spend weeks at a time on her back. Twenty-two weeks after conception, she delivered a baby that died one-and-a-half hours after birth. Doe never received the full \$10 000 payment for delivering a live baby. Keane initially offered her \$1,000 — the standard amount for a miscarriage, which she refused. After seven months of haggling, Keane paid her \$7,000. (M. Gladwell and R. Sharpe, "Baby M Winner: Meet the Surrogacy Entrepreneur," *New Republic* 106 (16 February 1987), 15).

157. Andrews, *supra*, note 11, 86.

Further, Mr. Handel has told carrying women that though the arrangements are not enforceable at law, he will sue them in tort for intentional infliction of emotional distress. He has made each carrying woman sign a statement that she understands the baby is the couple's child and she is their last resort for a child; and that she and her husband understand if she tries to keep the child, they will have intentionally inflicted emotional distress on the couple. Lori B. Andrews quotes him speaking to a prospective carrying woman thus:

If you change your mind, I will nail you to the wall ... I will sue you outside of the contract for destroying two human beings in a lawsuit that will

probably garnish millions of dollars in judgments and is not dischargeable in bankruptcy. I will follow you the rest of your lives. You will not have a job, car, or house that I will not go after. It will be the most expensive child you've ever decided to keep. (*Ibid.*, 87)

Apparently, the intimidation of women does not stop there. When one carrying woman sought to keep the child, the unnamed broker

threatened me. He said they'd make things really hard for me to keep my baby. He didn't get explicit. But I knew he'd threatened other surrogate mothers ... Another surrogate said this guy could make your life absolute hell. He'd have a battery of lawyers against you. He'd make sure you had to pay every penny back or get you into jail if you couldn't pay it back fast enough. The broker told me that he had a hunch I was on welfare and that he was going to check the county welfare records and report me for trying to earn money as a surrogate if I backed out of the deal. (*Chesler, supra*, note 15, 62-63)

158. "Surrogate Mothers of Invention," *supra*, note 16.
159. Arking, *supra*, note 59.
160. Quoted in Kopecky, *supra*, note 151, 143.
161. Gladwell and Sharpe, *supra*, note 156, 16.
162. Parker, *supra*, note 106.
163. Gladwell and Sharpe, *supra*, note 156, 16.
164. S. Katz, "The New Reproductive Era: Doctors Will Face New Ethical Challenges," *Canadian Medical Association Journal* 136 (1987), 1293.
165. Lasker and Borg, *supra*, note 60, 117-18.
166. Summary of Hilary Hanafin's "Reassessing Human Bonding," summarized by the Center for Surrogate Parenting in its *Catalogue of Position Papers on Surrogacy*. For a brief description of the Downs case, see note 81.
167. *Baby M*, *supra*, note 1; and 537 A. 2d 1227 (N.J. Sup. Ct. 1988).
168. "Seven-Week Trial Touched Many Basic Emotions," *New York Times* (1 April 1987), B2.
169. In December 1986, the *San Diego Tribune* ran an article entitled, "Surrogate Mothers: Not All Regret or Reneges on the Delicate Pact"; On 1 January 1987 the *Los Angeles Times* published "Surrogate Mother Extols 'Joy of Life' in Novel Experience." Both describe William Handel and his practice. In June 1987 an article featuring Betsy Aigen's firm appeared in *McCall's*, entitled, "Searching for a Very Special Woman," *supra*, note 59.
170. *Supra*, note 158.
171. *Supra*, note 75, 5.
172. "ABC Nightline," 3 February 1988, Transcript #1748, 4.
173. Frank and Vogel, *supra*, note 37, 214.
174. Kunen, *supra*, note 69.

175. Frank and Vogel, *supra*, note 37, 215. Indeed, Noel Keane placed an ad around 1982 in two Toronto newspapers "seeking prospective carrying women." In response, the then Ontario Community and Social Services Minister Frank Drea "threatened to 'knock the bows off [Mr. Keane's] loafers'" if he tried to continue operating in Ontario. He vowed Ontario would not become the spawning ground for a "cottage industry" where babies would be sold "primarily for the profit of an American solicitor." "Social Studies," *supra*, note 35.
176. Frank and Vogel, *supra*, note 37, 215.
177. *Supra*, note 68.
178. Andrews, *supra*, note 11, 30.
179. Testimony of Harriet Blankfield and Richard Levin in *Hearing on a Bill to Prohibit Certain Arrangements Commonly Called Surrogate Motherhood*, *supra*, note 84, 137-39 and 111-13. With regard to Levin's testimony that his firm engages in careful psychiatric screening of carrying women, compare text in note 81.
180. Center for Surrogate Parenting Inc., *Newsletter* 1 (Summer 1989), 2.
181. Quoted in Andrews, *supra*, note 9, 211.
182. "West 57th," *supra*, note 4, 6. His other locations are Indianapolis, a suburb of San Francisco, and New York City, though this latter location might close as a result of the passing of prohibitory New York legislation, which is effective 17 July 1993. See the subsection "Brokers" of "Participants in Preconception Arrangements" in Part 1 and notes to subsection "Statutes" in Part 6.
183. "Three More Surrogate Babies Expected," *The Times* (16 January 1984); "Surrogate Pregnancies in Britain," *The Times* (22 May 1984); "First Surrogate Births Are on the Way," *The Guardian* (22 May 1984).
184. See the section "United Kingdom" in Part 6.
185. U. Winkler, "New U.S. Know-How in Frankfurt — A 'Surrogate Mother' Agency," *Reproductive and Genetic Engineering* 1 (1988), 206.
186. "West German Ructions over U.S. Surrogacy Company," *Nature* (15 October 1987), 577; Winkler, *supra*, note 185; "American Irks Bonn as an Agent for Surrogate Births," *New York Times* (4 January 1988), A11; "German Court Shuts Center for Surrogate Motherhood," *New York Times* (7 January 1988), A11.
187. Patti Foster quoted in G. Corea, "Junk Liberty," in *Reconstructing Babylon: Essays on Women and Technology*, ed. H.P. Hynes (Bloomington: Indiana University Press, 1991), 150.
188. "Bid to Offer Surrogate Motherhood Service in Calgary Approved by Hospital's Board," *Medical Post* (26 January 1993), 48.
189. U.S. Congress, Office of Technology Assessment, *Infertility: Medical and Social Choices* (Washington, DC: U.S. Government Printing Office, 1988), 295; a study prepared for the Royal Commission on New Reproductive Technologies reported that, in Canada, the success rates claimed by IVF centres were 10 to 20 percent for a live baby. R. Mickleburgh, "Fertility Programs Attacked in Study," *Globe and Mail* (28 April 1993), A1.
190. OTA, *supra*, note 189.
191. *Ibid.*

192. Ibid.
193. L.A. Sheean et al., "In Vitro Fertilization (IVF) — Surrogacy: Application of IVF to Women Without Functional Uteri," *Journal of In Vitro Fertilization and Embryo Transfer* 6 (1989): 134-37. In their report of six cases, the commissioners ranged in age from 26 to 37 years and the average age was 30.6; the carrying women ranged from 22 to 29 years, with the average age 25.3 years. Results of clinical experience reported by a second researcher, Wulf Utian, revealed that the "commissioners ranged in age from 26 to 45 years with 58% over 35 years. By contrast, the carrying women were all less than 35 years of age." W.H. Utian et al., "Preliminary Experience with In Vitro Fertilization — Surrogate Gestational Pregnancy," *Fertility and Sterility* 52 (1989): 633-38. Bill Handel and Hilary Hanafin reported that the 22 commissioners ranged in age from 33 to 47 years of age. The carrying women were all younger than 32 years of age except one who was 36 years old. W. Handel and H. Hanafin, "Success Rate of Surrogate Gestational Pregnancies Using In Vitro Fertilization Donor Oocytes," paper presented at the Sixth World Congress on IVF, Jerusalem, 1989, in *Advances in Assisted Reproductive Technologies*, ed. M. Shlomo et al. (New York: Plenum Press, 1990).
194. In Sheean's report, the gestational women were required already to have one or more young children. Handel reported that the gestational women were only those "who had successful, uncomplicated pregnancies and who had children of their own." Handel, *supra*, note 193, 658.
195. R.J. Paulson, M.V. Sauer, and R.A. Lobo, "In Vitro Fertilization in Unstimulated Cycles: A New Application," *Fertility and Sterility* 51 (1989): 1059-60. Also, J. Garcia, "Return to the Natural Cycle for In Vitro Fertilization (Alleluia! Alleluia!)," *Journal of In Vitro Fertilization and Embryo Transfer* 62 (1989): 67-68.
196. Sheean et al., *supra*, note 193, 136.
197. Handel and Hanafin, *supra*, note 193, 661.
198. Ibid.
199. Sheean et al., *supra*, note 193, 136.
200. Utian et al., *supra*, note 193, 638.
201. Sandberg, *supra*, note 93, 1446.
202. P. Steptoe, Letter, *British Medical Journal* (27 June 1987): 1688-89.
203. Quoted in C. Lawson, "Couples' Own Embryos Used in Birth Surrogacy," *New York Times* (12 August 1990), A1.
204. Testimony before the Royal Commission on New Reproductive Technologies, Vancouver, 26 November 1990. The argument that preconception arrangements constitute medical treatment is analyzed at length below in Part 5.
205. Quoted in "Enforceability Needed for Surrogate Parents' Agreements," *Lawyers Weekly* (20 June 1986), 12.
206. Sandberg, *supra*, note 93, 1443.
207. Ibid., 1446.
208. Ibid.
209. Ibid.

210. See, for example, J.A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth," *Virginia Law Review* 69 (1983): 405-65.
211. Margrit Eichler, interview, December 1991.
212. Nancy Barrass claims that she suffered in this way. "My contract was breached, I was given a sexually transmitted disease during insemination. I was given massive doses of fertility drugs which caused extenuating problems." "Donahue," *supra*, note 112, 4.
213. K.M. Dixon et al., "A Case of Surrogate Pregnancy," *Journal of Family Practice* 30 (1990), 20.
214. Frank and Vogel, *supra*, note 37, 165.
215. Ibid.
216. Wood and Singer, *supra*, note 8, 428.
217. Frank and Vogel, *supra*, note 37, 172.
218. R. Stirzinger and G.E. Robinson, "The Psychological Effects of Spontaneous Abortion," *Canadian Medical Association Journal* 146 (1989): 799-800. Stirzinger and Robinson cite D. Anderson, "The Emotional Impact of Miscarriage," M.Ed. thesis, Ontario Institute for Studies in Education, 1987.
219. M. Seibel and W.L. Graves, "The Psychological Implications of Spontaneous Abortion," *Journal of Reproductive Medicine* 25 (1980): 161-65.
220. "Don't Take My Babies from Me," *Good Housekeeping* (March 1988), 186-87.
221. See, generally, G. Corea, "Industrial Experimentation on 'Surrogate' Mothers," in *Reconstructing Babylon: Essays on Women and Technology*, ed. H.P. Hynes (London: Earthscan Publications, 1989).
222. Gladwell and Sharpe, *supra*, note 156.
223. C.H. Zeanah, "Adaptation Following Perinatal Loss: A Critical Review," *Journal of American Academy of Child and Adolescent Psychiatry* 28 (1989), 468.
224. Keane Agreement, paragraph 9.
225. M.B. Whitehead, *A Mother's Story* (New York: St. Martin's Press, 1989), 93-94.
226. In Ontario, for example, in 1986, the maternal mortality rate was 4.5 per 100 000 live births. Committee on Reproductive Care, *Ontario Mortality Review for 1986*, 96.
227. Denise Mounce died of a "pre-existing heart condition" exacerbated by the pregnancy. "Sally Jessy Raphael," *supra*, note 115, 3.
228. Overvold, *supra*, note 99, 130.
229. Ibid.
230. "I Was the Carrier, a Postman Delivering a Very Special Parcel," in "Love and Money" Motivated Surrogate Mom," *Toronto Star* (31 July 1985), D20; "Motherhood Is Not Biological," "Sandra," speaking on "Geraldo," *supra*, note 77, 9; "I loved that child for nine months, but I didn't fool myself into thinking it was mine," Andrews, *supra*, note 11, 277; "I wanted the wife to experience her pregnancy — I do not think of it as my pregnancy," Frank and Vogel, *supra*, note 37, 158; "It's the father's child ... I'm simply growing it for him"; Hall, *supra*, note 24, 53.

231. Overvold, *supra*, note 99, 133.
232. "Views on Surrogacy Harden After Baby M Ruling," *New York Times* (2 April 1987), B2.
233. See the subsection "A More Complete Picture of Supply" in this part, above.
234. Kane, *supra*, note 64, 107-108.
235. Hanley, *supra*, note 137, B4.
236. Whether a particular woman is harmed by relinquishment at the time might vary. According to one commentator,

At the positive end of the scale, many of women surveyed ... said they walked away with a glow born of having performed a special act. At the negative end, these women experience everything from let down after an exciting experience to regret at having to give away the baby of their dreams. (Overvold, *supra*, note 99, 133)

Some women appear to relinquish the child with minimal distress:

I told him that he was a very special boy, to love his mother and father and to have a good life ... I'm sure I'll be emotional about it for years, but I know that I did the right thing. (*Woman's Own*, *supra*, note 3)

Other women have had more difficulty:

I got in the car. The nurse put the baby in my arms. I was fine. Then, I looked down at her. I went to get out of the car to give her to her parents and I just collapsed, sobbing, in the seat. Uncontrollable sobs. I don't know what it was. I wanted them to have her. I knew I couldn't raise another baby. But something hit me. (D. Snyder, "Stand-in Mother," *Health* 17 (April 1985), 67)

Mary Beth Whitehead writes about her relinquishment of "Baby M,"

They got up to leave. I went with them to the door. "I always knew the day would come when you would be left empty-handed," Bill admitted sadly. I watched as he put Sara in a baby seat in the back of the car. I looked at her alone in the seat, all curled up like a little rubber ball. Then, as I stood at the door, they drove away.

I collapsed on my front steps ...

All I did was sob and cry. I just couldn't stop crying. It just kept coming, and the emptiness that I felt was something I never want to feel again.

Eventually I fell asleep. Suddenly I opened my eyes. The room was dark, and I was lying in a pool of milk. The sheets were full of milk. I knew it was time to feed my baby. I knew she was hungry, but I could not hear her crying. The room was quiet as I sat up in the bed, alone in the darkness, with the milk running down my chest and soaking my nightgown. I held out my empty arms and screamed at the top of my lungs, "Oh God, what have I done — I want my baby!" (Whitehead, *supra*, note 225, 24, 26-27)

According to proponents of the practice, however, cases like the *Baby M* case are atypical. For example, Lori Andrews argues,

In the vast majority of cases everything does turn out all right for all the couples involved, so the real point is how to handle conflict in those rare

- cases where something does go wrong. (Lori B. Andrews on "Donahue," *supra*, note 112)
237. See *supra*, text at note 24. See also text at notes 234, 277, 288, and 293.
238. Andrews, *supra*, note 11, 34.
239. *Ibid.*, 35.
240. *Ibid.*, 143-44.
241. Noel Keane on "ABC Nightline," *supra*, note 75, 4.
242. Andrews, *supra*, note 11, 91-92 (emphasis in original). For other arguments that preconception arrangements are analogous to adoption, see the subsection "The Carrying Woman's Relinquishment of Maternal Rights" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
243. *Ibid.*, 267. See also the discussion of Andrew's position that adoption law is not applicable to preconception arrangements in the subsection "The Carrying Woman's Relinquishment of Maternal Rights" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
244. *Ibid.*, 268.
245. These traits were used to distinguish adoption from other forms of perinatal losses. J.T. Condon, "Psychological Disability in Women Who Relinquish a Baby for Adoption," *Medical Journal of Australia* 144 (1986), 117. Condon includes a fourth trait: "women perceive their efforts to acquire knowledge about the child (which would give them something 'to let go of') as being blocked by an uncaring bureaucracy."
246. With respect to the first trait of relinquishing mothers, consider a carrying woman's account of her sense that she had no alternative: "I was a surrogate and I gave up my child and I regret it, deeply and emotionally. I can't walk by a baby store, I see people with carriages, it's not what it's cracked up to be. People try and counsel you, but what are they counselling? They're counselling you to give up your baby, they're not counselling free choice. You're all up here talking about free choice, there is no free choice for a surrogate." Audience member, "Should Women Rent Wombs?" "Sally Jessy Raphael," *supra*, note 115, 13. The second trait, difficulty in saying goodbye, is also experienced by carrying women: "Through the whole pregnancy I was motivating myself, trying to put my state of mind into what I wanted it to be for the delivery and after. But it was still very hard, that separation, much harder than I thought it would be. I wonder how she's doing, what kind of a life she'll have. I wish I had thought to ask the couple if I could be the guardian of the baby if anything happened to them. But I know I have to try not to think about her. Her birthday is especially hard, I always get depressed then." A carrying woman quoted by Lasker and Borg, *supra*, note 60, 115.
247. E.K. Rynearson, "Relinquishment and Its Maternal Complications, A Preliminary Study," *American Journal of Psychiatry* 139 (1982), 338; R. Winkler and M. van Keppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment* (Melbourne: Institute of Family Studies, 1984); E.Y. Deykin, L. Campbell, and P. Patti, "The Postadoption Experience of Surrendering Parents," *American Journal of Orthopsychiatry* 54 (1984), 271; L. Millen and S. Roll, "Solomon's Mothers: A Special Case of Pathological Bereavement," *American Journal of Orthopsychiatry* 55 (1985),

- 411; Condon, *supra*, note 245; Letters to the Editor, "Relinquishing Mothers," *Medical Journal of Australia* 144 (1986), 553.
248. Deykin et al., *supra*, note 247, 271. Deykin notes that the applicability of her findings might be limited since the study sample consisted of a volunteer subset of an already self-selected population. Most of the women were participants in a support group called "Concerned United Birth Parents."
249. Rynearson, *supra*, note 247, 338.
250. Deykin et al., *supra*, note 247, 271.
251. Winkler and van Keppel, *supra*, note 247.
252. Condon, *supra*, note 245, 117.
253. Deykin et al., *supra*, note 247, 280.
254. Three (10%) surrogates sought psychiatric treatment or counselling to help them deal with the grieving process or subsequent depression, one was briefly on anti-depressant medication ... The surrogate's response to the relinquishment of the child to the parental couple often encompassed anger as well as grief and sadness. Some were able to experience anger and resentment toward the couple who had received the relinquished newborn ...
- Most surrogates expressed thoughts of wondering how the baby would fare in the future ... Some wished that they could maintain a relationship but were refused by the couple; they often felt angry and unhappy about the enforced exile from the parental couple and their new child.
- Several surrogates consciously expressed a desire to have their own replacement child to help deal with the feelings of sadness and loss. Several are again attempting to be surrogate mothers while a few said they would never do it again. Most surrogates acknowledged increased thoughts of the child on the anniversary of the birth." (Parker, *supra*, note 106, 11-12)
255. Steptoe, *supra*, note 202.
256. J. Leeton, C. King, and J. Harman, "Sister-Sister In Vitro Fertilization Surrogate Pregnancy with Donor Sperm: The Case for Surrogate Gestational Pregnancy," *Journal of In Vitro Fertilization and Embryo Transfer* 5 (1988), 247.
257. The profound nature of the effect of pregnancy irrespective of the ovum's origin has been described by S. O'Brien, "The Itinerant Embryo and the Neo-Nativity Scene: Bifurcating Biological Maternity," *Utah Law Review* (1987), 24-25.
258. G.J. Annas, "Fairy Tales Surrogate Mothers Tell," *Law, Medicine & Health Care* 16 (1-2)(1988), 28.
259. C.E. Schneider, "Surrogate Motherhood from the Perspective of Family Law," *Harvard Journal of Law & Public Policy* 13 (Winter 1990), 130.
260. Ibid., 130-31.
261. Speaking on "Donahue," 28 February 1989, Transcript #2631, 13.
262. Mary Beth Whitehead-Gould quoted in D.P. Mayes, "Surrogate Mom's Happier Now and Smarter Too," *Sunday Star* (12 March 1989), D8. It is possible that Anna Johnson had a similar experience during the trial to determine who would have

custody of the boy to whom she gave birth. Consider how she was discussed on television by the commissioners and the talk show host while she was still pregnant:

Geraldo: Well, do you Mark, think that it's all for money that she's doing this?

Chris Calvert, using surrogate: Basically for publicity and financial consideration probably.

Geraldo: Do you think Chris, that she wants to get more money from you?

Mark Calvert: We really can't speculate on her motives, however, that probably is a primary reason ...

Geraldo: Before I go on with this specific question, I really have to ask you again, what is her motive? Is it possible, in your minds, that she really has bonded with the child growing inside her?

Mrs. Calvert: I don't think she has bonded with the child ... ("Wombs for Rent," "Geraldo," 17 September 1990, Transcript #783, 3-4)

263. "Surrogate Mom Feels Bad About Keeping Her Child," *Toronto Star* (10 November 1983), F3.

264. S. Nickman, "Losses in Adoption," *Psychoanalytic Study of the Child* 40 (1985), 365. See also C.A. Colarusso, "Mother, Is That You?" *Psychoanalytic Study of the Child* 42 (1987): 223-37; M. Humphrey and H. Humphrey, "A Fresh Look at Genealogical Bewilderment," *British Journal of Medical Psychology* 59 (1986), 133; B.Z. Sokoloff, "Alternative Methods of Reproduction: Effects on the Child," *Clinical Pediatrics* 26 (January 1987): 11-16.

265. See *supra*, text at notes 45 and 54.

266. W.R. Frederick et al., "HIV Testing of Surrogate Mothers," *New England Journal of Medicine* 317 (1987): 1351-52.

267. Cynthia Gorney quoting a commissioning woman in "Having Their Baby," *California Magazine* (1 October 1983), 155.

268. Michael Small quoting commissioners, "Baby Sellers or Sisters of Mercy?" *People* 26 (20 October 1983), 46.

269. Anna Quindeen quoting Dr. Richard Levin, "Surrogate Mothers: A Controversial Solution to Infertility," *New York Times* (27 May 1980), B12.

270. Andrews, *supra*, note 9, 210, quoting attorneys for the State of Michigan.

271. J.H. Steadman and G.T. McCloskey, "The Prospect of Surrogate Mothering: Clinical Concerns," *Canadian Journal of Psychiatry* 32 (1987), 545.

272. This is the argument of, for example, the National Association of Surrogate Mothers. See Andrews, *supra*, note 11, 236.

273. Bill Handel quoted by Andrews, *supra*, note 9, 193.

274. I.G. Leon, "The Invisible Loss: The Impact of Perinatal Death on Siblings," *Journal of Psychosomatic Obstetrics and Gynecology* 5 (1986): 1-14.

275. Steadman and McCloskey, *supra*, note 271, 547.

276. Leon, *supra*, note 274.

277. Steadman and McCloskey, *supra*, note 271. Elizabeth Kane claims that her three-year-old son Jeffrey suffered from the relinquishment of his half-brother:

I left the house in labor, frightened and enormous with the weight of the child within. One week later, I returned home slimmer, tired, trying to be cheerful. The child had disappeared.

Jeffrey would look at pictures of babies and grow sad. "Oh. Baby's gone." He would shake his head sadly and stroke my flat abdomen, no longer able to feel a tiny foot kicking against his hand. It was impossible for him to understand.

Further, Kane argues, the suffering has not diminished over time:

Today at the age of eleven, he ... is a clinging, fearful child plagued by constant nightmares. Recently he has become afraid of death — especially mine. He will cry and be unable to fall asleep if he hears of the death of an unknown person on the evening news. His behavior completely bewilders me.

A psychologist apparently explained to her that her child's problems lie in his inadequate understanding of what happened:

Your son is undergoing classic symptoms of grief and loss. It's as though you gave birth to a dead child, came home empty-handed, and never mentioned the baby again. There was no funeral, no family grieving and little mention of the loss of his brother ... get immediate professional help to draw out the denial in this child. (E. Kane, *Birth Mother* (San Diego: Harcourt Brace Jovanovich, 1988), 280-81)

278. Leon, *supra*, note 274, 2 and 8.

279. Andrews, *supra*, note 11, 84-85.

280. L.B. Andrews, "Surrogate Motherhood. The Challenge for Feminists," in *Surrogate Motherhood: Politics and Privacy*, ed. L. Gostin (Bloomington: Indiana University Press, 1990), 177.

281. Andrews, *supra*, note 280.

282. *Ibid.*

283. Peterson, *supra*, note 135, B4.

284. Nancy Barrass speaking on "Donahue," *supra*, note 112, 14. Elizabeth Kane's older children similarly have not accepted their mother's actions and appear harmed by them.

Laura has suffered the most. Shortly after the birth, she sat at the breakfast table, unable to eat the Cheerios floating in her bowl. She covered her face with both hands and sobbed, "I never got to hold my baby brother!"

In speechless terror, I watched her thin shoulders shake. I knew I could try to deny he was my son. I had told the world he belonged to another woman. But Laura knew the truth. He is her brother. Nothing that is said or done can ever change that fact. They share the same blood, the same grandparents, and the same mothers. I was unable to stand there and tell her she was wrong. Justin's absence was like a death. We had to mourn

it together.

During succeeding months, she was able to verbalize her anguish, but as the years passed, she grew pensive and withdrawn, retreating to her bedroom every time we received photographs of Justin. Any effort on my part to talk about the surrogacy or Justin would result in a stream of obscenities and a wall-shaking slam of her bedroom door. Through counselling we attempted to resolve our differences and her alleged loss of respect for me. The effort was short-lived and futile. Today our conversation remains stilted and veiled. In spite of my sadness over our damaged relationship, I have learned not to feel guilty. I know I cannot be responsible for the ways she perceives my actions. (Kane, *supra*, note 277, 279-80)

285. See text at note 238.

286. Andrews, *supra*, note 11, 50.

287. *Ibid.*, 50-51.

288. It is a truism that children's attitudes change. For example, Elizabeth Kane said in 1981 that she had discussed the matter with her children. "They're intelligent and perceptive. They thought it a wonderful way to deal with infertility and help a stranger who desperately needed something I could give." Despite what they said then, the children obviously suffered later from the experience. Markoukas, *supra*, note 24, 79. See also comments by carrying women, Lasker and Borg, *supra*, note 60, 116.

289. Steadman and McCloskey, *supra*, note 271, 547.

290. Andrews, *supra*, note 9, 214.

291. *Ibid.*, 213-15.

292. A man whose wife refused to relinquish twins explained the impact on his life of his wife's pregnancy thus:

I've been supporting her through this pregnancy. I've gone through it, and I'm the one that held her head up when she threw up. I'm the one who cooks her meals and cleans up after her. (Richard Yates speaking on CBS News, "60 Minutes," 20 September 1987, 6)

293. Sokoloff, *supra*, note 264, 14.

294. S. Downie, *Babymaking: The Technology and the Ethics* (London: Bodley Head, 1988), 124. Elizabeth Kane also describes how the very different roles each played in the creation of her son had a divisive effect on their relationship:

I have lost a child. Kent has not. We no longer relate to each other in the same manner we once did. The closeness and respect have diminished. There is little real communication after twenty-one years of marriage.

Recently, while cleaning out a desk drawer, I found some notes Kent had made during my pregnancy. His feelings about the possible break-up of our marriage and his feigned acceptance of my surrogacy — his fears for all of us following the birth — saddened me. He never once revealed those feelings to me.

The psychologist ... confirmed my feelings about the difficulties that surrogacy had presented in our marriage. "Each time your husband looks at a photograph of Justin, he is reminded of your bond with another man. As though you had taken a lover. Your son by this stranger might very well have qualities that Kent wished his own son had. This could only add to feelings of low self-esteem. (Kane, *supra*, note 277, 281-83)

295. Frank and Vogel, *supra*, note 37, 166. The woman in Argentina described above in the subsection "A More Complete Picture of Supply" told an interviewer how the agreement was destructive to her relationship and how her husband came to think of her pregnancies as a money-making enterprise.

Amelia: ... The whole thing did not go well for my husband, specially at the time to go to bed. He did not even touch me for a long while and if I would reach for him he would reject me. Afterwards he started to drink more than usual, and then he would not get angry, but he was weird, different from how he had always been ... and I did not like that, that scared me a lot ... he wanted to do things that we never had done ... and I felt that he was doing it because he thought I had betrayed him, as if it was a punishment.

Her employers asked her to carry another child. Though she suffered a great deal by relinquishing the child, and she appeared unwilling, she feared displeasing her husband:

Amelia: ... I am afraid to get into too much trouble, specially with my husband.

Reporter: He does not want to?

Amelia: No, on the contrary, he thinks it is a good idea, he says that with the money that we could get we could live in some other place. (Arditti, *supra*, note 88, 40, 42-43)

296. See, for example, Crawford, *Toronto Star* (2 April 1987), F1. "Her parents were unhappy about the arrangement particularly her father who is concerned that he has a grandchild who doesn't know him." See also *Woman's Own*, *supra*, note 3. "Her own mother was upset because she felt she was losing a grandchild and her father-in-law disinherited her."

297. See the section "Analysis of Demand," above.

298. "Carol," speaking on "Geraldo," *supra*, note 77, 7-8.

299. "Sandra," speaking on "Geraldo," *supra*, note 77, 8.

300. See the subsection "The Effect of the Common Picture of Demand in Generating and Characterizing Supply" of "Analysis of Supply" in this part, above.

301. L. Savory, "At What Price, Freedom? — the Surrogate Motherhood Debate," *Waterlily* 2 (Fall 1990), 20.

302. "I Had to Pay Another Woman to Have My Baby," *Good Housekeeping* 202 (April 1986), 34.

303. *Ibid.*

304. "Judge Orders Co-Custody in Surrogate Case," *Los Angeles Times* (27 September 1991), A27.

305. See the subsection "The Effect of the Common Picture of Demand in Generating and Characterizing Supply" of "Analysis of Supply" in this part, above.
306. "Little Girl, Big Trouble," *People* 31 (20 February 1989), 38.
307. *Ibid.*
308. Raymond, *supra*, note 68, 8.
309. As the *Anna J v. Mark C* case demonstrated, it is possible for a white or Filipino couple to hire a Black or Native American woman to give birth to a child genetically related to the commissioners.
310. John Stehura, quoted in Corea, *supra*, note 25, 245.
311. OLRC, *supra*, note 1, 242.
312. *Supra*, note 5, 129.
313. OLRC, *supra*, note 1, 252; "Draft ABA Model Surrogacy Act," *supra*, note 5, 133.
314. J.G. Raymond, "The International Traffic in Women: Women Used in Systems of Surrogacy and Reproduction," *Reproductive and Genetic Engineering* 2 (1989), 56.
315. See "The Effect of Third Parties' Interests and Activities: Brokers," above and note 157.
316. R. Arditti, "Wombs for Rent, Babies for Sale," *Sojourner* (March 1987), 11.

Notes to Part 4

1. J.A. Robertson, "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction," *Southern California Law Review* 59 (1986), 958.
2. 262 U.S. 390 (1923).
3. 316 U.S. 535 (1942).
4. 405 U.S. 645 (1972).
5. Robertson, *supra*, note 1, 960.
6. J.A. Robertson, "Procreative Liberty, Embryos and Collaborative Reproduction," paper presented at the U.K. National Committee of Comparative Law 1987 Colloquium "Legal Regulation of Reproductive Medicine," Girton College, Cambridge, England, 15-17 September 1987, 2.
7. "Interview with John A. Robertson: Life, Liberty and Children," *ABA Journal* 73 (1 June 1987), 39.
8. See below, Appendix 1: "United States Privacy Cases and the Right to Procreate."
9. J.A. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction," *Law, Medicine & Health Care* 16 (1-2)(1988), 19.
10. *In the Matter of Baby "M,"* 537 A. 2d (N.J. Sup. Ct. 1988) 1227 at 1249 per Wilentz J.
11. J.A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth," *Virginia Law Review* 69 (1983), 408.
12. *Ibid.*, 408-409.

13. Ibid., 424.
14. Ibid., 409.
15. Ibid., 410.
16. Ibid.
17. Ibid.
18. See, generally, M. O'Brien, *The Politics of Reproduction* (London: Routledge and Kegan Paul, 1981), especially chap. 1.
19. Robertson, *supra*, note 11, 410.
20. Ibid., 434-35.
21. Ibid., 443.
22. Robertson, *supra*, note 6, 16-17.
23. Robertson, *supra*, note 11, 424.
24. Ibid.
25. Ibid., 433.
26. Ibid., 433-34.
27. Ibid., 434.
28. Ibid.
29. Ibid.
30. See the section "Participants in Preconception Arrangements" in Part 1.
31. Robertson, *supra*, note 6, 17.
32. Robertson, *supra*, note 11, 425.
33. Robertson, *supra*, note 6, 17.
34. Ibid.
35. Ibid.
36. Ibid.
37. See note 31 in Notes to Appendix 1.
38. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985) [hereinafter OLRC].
39. American Fertility Society, Ethics Committee, "Ethical Considerations of the New Reproductive Technologies," *Fertility and Sterility* 53 (Suppl. 2) (1990) [hereinafter AFS].
40. OLRC, *supra*, note 38, 232.
41. AFS, *supra*, note 39; 64S and 69S.
42. OLRC, *supra*, note 38, 237.
43. Ibid.
44. AFS, *supra*, note 39, 65S.

45. An example of such a case is that of commissioners Robert Moschetta, aged 35, and Cynthia Moschetta, aged 51. M. Lait, "Judge Orders Co-Custody in Surrogate Case," *Los Angeles Times* (27 September 1991), A3.
46. According to carrying woman Patti Foster, these were the circumstances of the commissioners in her preconception arrangement, the Stein family. CTV, "Shirley," 1 February 1991.
47. This is one of the "medical reasons why a couple may seek the assistance of a surrogate mother." The illness "would render a pregnancy a risk to her life or health." OLRC, *supra*, note 38, 236.
48. These are some of the "medical indications" for a woman to call on a surrogate gestational mother to carry the pregnancy for her. AFS, *supra*, note 39.
49. OLRC, *supra*, note 38, 231.
50. AFS, *supra*, note 39, 65S.
51. Payment to organ donors is prohibited in Ontario by the Human Tissue Gift Act, R.S.O. 1980, c. 210, s. 10. In the United States, payment is condemned by the Transplantation Society. In 1984 it announced: "The International Transplantation Society, the American Society of Transplant Surgeons, and the American Society of Transplant Physicians strongly condemn the recent scheme for commercial purchase of organs from living donors. This completely morally and ethically irresponsible proposal is rejected as abhorrent by all members of the Transplantation Societies. Removal of organs and transplantation of organs obtained commercially will not be handled by any member of the Transplantation Societies, and anyone doing so will be expelled." *Transplantation Proceedings* 16 (1984).
52. OLRC, *supra*, note 38, 253-55.
53. AFS, *supra*, note 39, 65S and 73S.
54. OLRC, *supra*, note 38, 249-53. Under the proposal of the AFS, preconception arrangements would be pursued as a clinical experiment and then "if surrogate gestational motherhood turns out to be useful, a change in the law would be appropriate for assurance that the genetic parents who contract with a surrogate gestational mother are viewed as the legal parents." AFS, *supra*, note 39, 67S and 73S.
55. The AFS inconsistently argues that what the carrying woman "donates" is a "function": her ability to gestate and give birth. But, of course, it is the child who is the subject of the donation, otherwise the AFS would not contemplate forced transfer of the child once the carrying woman had exercised her reproductive function by gestating and giving birth.
56. AFS, *supra*, note 39, 68S.
57. OLRC, *supra*, note 38, 232.
58. AFS, *supra*, note 39, 73S.
59. OLRC, *supra*, note 38, 232.
60. AFS, *supra*, note 39, 70S.
61. For other arguments that preconception arrangements are not medical treatment, see J. La Puma, D. Schiedermayer, and J. Grover, "Surrogacy and

Shakespeare: The Merchant's Contract Revisited," *American Journal of Obstetrics and Gynecology* 160 (1989): 59-62.

62. J. Waldron, "Theoretical Foundations of Liberalism," *Philosophical Quarterly* 37 (1987), 129-30.

63. L. Gostin, "A Civil Liberties Analysis of Surrogacy Arrangements," *Law, Medicine & Health Care* 16 (1-2)(1988), 8.

64. As Gostin argues,

The gestational mother has a particularly strong right of privacy and autonomy, founded upon several factors: her experience of artificial insemination, the changes in her body, her emotional commitment, her nurturing of the fetus for nine months, and the labor and pain of giving birth. The fact that she did not originally intend to keep the child does not dispose of this complex constitutional and social issue ... Her physical and psychological burdens deserve respect beyond the artificial confines of a sterile contract. (*Ibid.*, 8)

65. L.B. Andrews, "Surrogate Motherhood: The Challenge for Feminists," *Law, Medicine & Health Care* 16 (1-2)(1988), 73.

66. L.B. Andrews, *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies* (New York: Harper and Row, 1989), 159.

67. Andrews, *supra*, note 65.

68. *Ibid.*

69. Andrews, *supra*, note 66, 253.

70. J.A. Scutt, "Book Reviews," *Issues in Reproductive and Genetic Engineering* 3 (1990), 75.

71. Andrews, *supra*, note 65, 75.

72. *Ibid.*

73. Andrews speaking on "Geraldo," "Wombs for Rent," 17 September 1990, Transcript #783, 8.

74. C.E. Schneider, "Surrogate Motherhood from the Perspective of Family Law," *Harvard Journal of Law & Public Policy* 13 (Winter 1990), 127.

75. A man is not permitted to be married at the same time to two women no matter how much he might wish to take another wife whether for love or for her childbearing abilities in the face of his first wife's infertility. Criminal Code, R.S.C. 1985, c. C-46, s. 293.

76. R.A. Posner, "The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood," *Journal of Contemporary Health Law and Policy* 5 (1989), 22.

77. *Ibid.*, 23.

78. *Ibid.*, 25.

79. S. Katz describing Reame's research in "The New Reproductive Era: Doctors Will Face New Ethical Challenges," *Canadian Medical Association Journal* 136 (1987), 1293. Posner also claims that a "mature woman" who has given birth at least once before can anticipate what it would be like to relinquish a child. But rearing a child does not give one information about relinquishment *per se*. Posner

further claims that the *Baby M* publicity should give women warning of the perils of surrogacy. Yet, as has been demonstrated, that publicity was quickly countered by news stories that suggested that Mary Beth Whitehead was atypical. (See subsection "Brokers" of "The Effect of Third Parties' Interests and Activities" in Part 3.)

80. As Nancy Reame found, "Surrogate mothers [as a group] lacked adequate legal protection. This was in contrast to the adopting couples, who retained skilled lawyers to draw up contracts which satisfied their needs." Katz, *supra*, note 79, 1293. Consider also Susan Ince's description of her undercover investigation of the practice when she surreptitiously attempted to become a carrying woman for a "surrogate company":

The contract itself repeated three times that a surrogate might seek her own legal counsel, fee to be paid by the program, to further her understanding ... [Because of the high cost of independent legal consultation and because] surrogates had come back from their consultations with new doubts and questions ... I was strongly encouraged to see a nearby lawyer "not associated" with the program ... To my surprise, the independent consultation was held within earshot of the [broker], who was called on by the lawyer to interpret various clauses of the contract, and who kept a record of questions I asked.

Ince asked many questions of the lawyer and challenged a clause requiring her to undergo amniocentesis and to abort if the commissioners did not like the test results. The "independent" lawyer said, however, that the clause must remain.

He paraphrased the company officials: "The program works because it works the way it is. We cannot make big changes for the surrogate or the parents."

Before the final signing of the agreement, Ince was telephoned by the broker, who had become concerned while listening to her consultation with her lawyer. She admonished Ince for asking too many questions:

The program works because it is set up to work for the couple. You have to weigh why you are participating in the program. For the money only, or to do the service of providing the couple with a baby. To be very frank, we are looking for girls with both these motivations. I felt after the last visit that this is a gal looking for every possible way to earn that money, and that concerns me ... emotionally and in every other way that baby is not yours ... No contract is perfect for anyone, for anything. (S. Ince, "Inside the Surrogate Industry," in *Test-Tube Women: What Future for Motherhood*, ed. R. Arditti, R.D. Klein, and S. Minden (London: Pandora Press, 1989), 103, 104, 107-109)

81. M.B. Whitehead, *A Mother's Story* (New York: St. Martin's Press, 1989), 22.

82. *Ibid.*

83. See B. Dickens, "Artificial Reproduction and Child Custody," *Canadian Bar Review* 66 (1987), 73-74; B. Dickens, "Enforcement of Surrogate Motherhood Agreements," *Transplantation Today* 4 (May 1987), 22; and "Enforceability Needed for Surrogate Parents' Agreements," *Lawyers Weekly* (20 June 1986), 12, quoting Bernard Dickens. Curiously, Dickens sees this possibility as sufficient justification for taking children from their birth mothers, even where the mother does not want

more money or any money at all from the commissioner, but simply wants her child. Dickens would forcibly remove commissioned children from their mothers to protect the generally socioeconomically advantaged commissioners from the possibility (no matter how remote) that they might be exploited financially. Ironically, he views the commissioners as the parties to a preconception arrangement who are most in need of legal protection.

84. An externality can be defined as the divergence between private and social costs. It describes the situation by which voluntary contractual arrangements do not internalize all relevant interactions, for example, where costs are created by the contracting parties but are borne by third parties. C.J. Dahlman, "The Problem of Externality," *Journal of Law and Economics* 22 (1979): 141-62.

85. Curiously, the harm of capitalizing on the commissioning woman's vulnerability is viewed by Posner as an argument *in favour* of the practice. According to him, "Not only are [commissioning women] hurt if their ability to obtain a baby (necessarily not borne by them) is impeded by a ban on the enforcement of contracts of surrogate motherhood, but their already weak bargaining position in a marriage to a fertile husband is further weakened, for under modern permissive divorce law he is always free to 'walk' and seek a fertile woman to marry" (Posner, *supra*, note 76, 27). This is a strange argument for the enforcement of preconception arrangements. It implies that marriage is exclusively an economic bargain, the terms of which are continually negotiable and might include the wife's willingness to raise her husband's child by another woman. Secondly, it inconsistently presents, as an argument for the enforcement of preconception arrangements, the possibility that a man will not honour his agreement of marriage. If the commissioning man can abandon his marriage agreement because he wants a child, why should not the carrying woman be entitled to abandon her preconception agreement because she wants her child?

86. E. Anderson, "The Ethical Limitations of the Market," *Economics and Philosophy* 6 (1990): 179-205.

87. Anderson actually identifies a fifth characteristic, which is not relevant to preconception arrangements. Anderson's fifth characteristic of market relations is that an individual's influence on the provision and exchange of commodities is primarily exercised through "exit" not "voice" (in Hirschman's terminology). This description applies to market relations in "spot contracts," for example, the purchase of a newspaper at a newsstand, but is inapplicable to exchanges that take place over a long period of time, as do preconception arrangements.

88. Anderson, *supra*, note 86, 182.

89. Robertson, *supra*, note 1, 1003.

90. According to the AFS, each party to a preconception arrangement gains an advantage by the transaction: the commissioning woman receives a child more quickly than she would if she waited in an adoption line, and the child will be the child of her husband; the commissioning man receives his child; and the carrying woman receives "the chance to be altruistic," the enjoyment of pregnancy, the opportunity to overcome past losses through abortion or relinquishment, and the money that might help carrying women "to support their children and to remain at home to care for them." AFS, *supra*, note 39, 70S.

91. Gostin, *supra*, note 63, 10.

92. Andrews, *supra*, note 65.
93. Posner, *supra*, note 76.
94. Anderson, *supra*, note 86, 183.
95. This characteristic of being capable of exclusive enjoyment is what Ursula Franklin describes, in another context, as a "divisible benefit." U.M. Franklin, *The Real World of Technology*, CBC Massey Lectures Series (Toronto: CBC Enterprises, 1990), 69.
96. Robertson, *supra*, note 1, 962.
97. Anderson, *supra*, note 86, 183.
98. Robertson, *supra*, note 1, 962.
99. Ibid., 1022.
100. Ibid., 1023. In other places in his work, Robertson seems to acknowledge that the carrying woman is affected by procreation, but he does not consider that effect as sufficiently significant to diminish the "right to procreative liberty." See, for example, *ibid.*, 1031-32.
101. OLRC referring to the view of the Advisory Board, *supra*, note 38, 252.
102. *Ibid.*, 231.
103. *Ibid.*
104. AFS, *supra*, note 39, 67S and 73S.
105. Gostin, *supra*, note 63, 9.
106. Andrews' argument is that women must honour their preconception arrangements no matter what the personal cost to themselves because otherwise they will not be thought capable of taking responsible decisions. She has written, "My personal opinion is that it would be a step backward for women to embrace any policy argument based on a presumed incapacity of women to make decisions. That, after all, was the rationale for so many legal principles oppressing women for so long, such as the rationale behind the laws not allowing women to hold property." L.B. Andrews, "Alternatives Modes of Reproduction," in *Reproductive Laws for the 1990s*, ed. S. Cohen and N. Taub (Clifton: Humana Press, 1989), 369-70.
107. Posner, *supra*, note 76, 29, quoting Wilentz C.J.
108. Posner, *supra*, note 76, 29.
109. Posner, *supra*, note 76, 30, quoting Wilentz C.J.
110. Posner, *supra*, note 76, 30.
111. The argument of medical necessity would, as explained, limit commissioners to those who have "medical need." This criterion was shown to be incoherent. It is plausible to argue that the governing criterion is in fact ability to pay even according to the argument of medical necessity, for neither the OLRC nor the AFS discusses how this "medical treatment" would be provided to impecunious persons with the requisite "medical indications." The OLRC and the AFS therefore seem to assume that within the class of those with "medical indications" for a preconception arrangement, only those who can pay would have their "medical need" for a commissioned child fulfilled.

112. See, for example, Dickens, "Artificial Reproduction," *supra*, note 83, 72-74.
113. See, for example, the proposals of the AFS, *supra*, note 39.
114. See, for example, the proposals of the OLRC, *supra*, note 38, 281-85.
115. This example is chosen because it briefly and clearly articulates a legislative policy based on a market production model.
116. American Bar Association, Section of Family Law, "Draft ABA Model Surrogacy Act," *Family Law Quarterly* 22 (1988): 123-43 [hereinafter ABA Proposal]. This proposal was not adopted by the American Bar Association when it was presented to its House of Assembly in August 1988.
117. *Ibid.*, section 1(b).
118. *Ibid.*, section 5(o).
119. *Ibid.*, section 6(a).
120. *Ibid.*, section 6(c).
121. *Ibid.*, section 6(a).
122. *Ibid.*, section 6(c).
123. *Ibid.*, section 9(b)(2).
124. *Ibid.*, section 9(a)(3).
125. *Ibid.*, section 4(c)(2).
126. Bill Handel rejected the Calverts as prospective commissioners for this reason. He "examined the Calverts' finances and told them they couldn't afford him." M. Kasindorf, "And Baby Makes Four," *Los Angeles Times* (20 January 1991), 16.
127. ABA Proposal, *supra*, note 116, section 4.
128. *Ibid.*, section 4(b)(1)(B).
129. *Ibid.*, section 4(c)(3).
130. *Ibid.*, section 5(d)(1).
131. *Ibid.*, section 11(b).
132. *Ibid.*, section 1(a).
133. *Ibid.*, section 6(a).
134. *Ibid.*, section 5(j).
135. *Ibid.*, section 3(a).
136. Quoted by Franklin, *supra*, note 95, 32.

Notes to Part 5

1. U.M. Franklin, *The Real World of Technology*, CBC Massey Lectures Series (Toronto: CBC Enterprises, 1990), 27.
2. Gary Skoloff speaking on the "Phil Donahue Show," April 1987, Transcript #05087, 5.
3. K. Pollitt, "When Is a Mother Not a Mother?" *The Nation* (31 December 1990), 844.

4. Ibid.
5. Franklin views this aim as characteristic of holistic strategies, which themselves are based on a growth model of creation. *Supra*, note 1, 83.
6. A.M. Capron and M.J. Radin, "Choosing Family Law over Contract Law as a Paradigm for Surrogate Motherhood," *Law, Medicine & Health Care* 16 (1-2)(1988), 34.
7. It will be recalled that our analysis of the practice of preconception arrangements began in Part 2 with a legal consideration of their enforceability on the assumption that they would be governed by family law. Because that assumption has been disputed by proponents of the practice, we examined the premises and arguments of proponents in Parts 3 and 4. Part 3 demonstrated that the depiction of the practice upon which proponents rely is incomplete and misleading. In Part 4, we saw that their reliance upon this depiction and the inapposite market production model leads them to advocate that the practice be governed by contract law. Because Part 4 demonstrated that contract law is a method of legal regulation that would give rise to the very harms that legislative policy should aim to prevent, we rejected contract law and return now to family law and our original assumption that it is the applicable and appropriate body of law to govern the practice.
8. See the subsection "The Central Provisions" of "Legality of the Participants' Agreement" in Part 2.
9. See discussion in the subsection "Custody Transfer of the Commissioned Child" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
10. Child and Family Services Act, S.O. 1984, c. 55, ss. 131(3) and 131(8), as amended [hereinafter CFSA].
11. See discussion in the subsection "The Carrying Woman's Relinquishment of Maternal Rights" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
12. CFSA, *supra*, note 10, s. 145(4).
13. See discussion in the subsection "Payment for Adoption" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
14. CFSA, *supra*, note 10, s. 159.
15. See the subsection "Characterization by Third-Party Involvement" of "Definition" in Part 1.
16. See discussion in the subsection "Adoption by Commissioner(s)" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
17. CFSA, *supra*, note 10, s. 140(1).
18. New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (Albany: 1988) [hereinafter NY Task Force].
19. Ibid., 115.
20. Ibid., 117.
21. Ibid., 118.
22. Ibid., 120.
23. Ibid., 121.

24. Ibid.

25. Ibid., 139.

26. For other arguments endorsing this approach, see L. Sullivan, "Surrogacy: The Case for a Conventional Approach," *Medicine and Law* 10 (1991): 401-15; M. Garrison, "Surrogate Parenting: What Should Legislatures Do?" *Family Law Quarterly* 22 (1988): 149-72; and Capron and Radin, *supra*, note 6.

27. See the section "An Alternative Basis for Legislative Policy" in this part, above.

28. See the section "Legislative Policy Based on a Growth Perspective and Family Law" in this part, above.

29. S.O. 1986, c. 4, s. 17(1) as amended.

30. R.S.O. 1980, c. 68, s. 24(1) as amended [hereinafter CLRA].

31. S.C. 1986, c. 4, ss. 16-17 as amended.

32. See the subsection "Custody Transfer of the Commissioned Child" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.

33. CFSA, *supra*, note 10, s. 131(3).

34. Ibid., s. 131(8).

35. See *ibid.*, s. 159.

36. *Ibid.*, s. 160(4). After this report was prepared, it was recommended by the majority of the Law Reform Commission of Canada that there be no criminal sanction imposed on commissioners or carrying women for participating in an arrangement. They argued that

subjecting the infertile couple, who have already experienced the anguish of infertility, and the surrogate, who is trying to provide a solution to their problem, to the stigma of criminality and the ensuing consequences seems excessive and might still not dissuade couples who are only seeking to realize a legitimate desire. (Law Reform Commission of Canada, *Medically Assisted Procreation*, Working Paper 65 (Ottawa: LRC, 1992), 137)

The proposal made here, however, is not that a new criminal offence be created but that an existing regulatory offence be made clearly applicable to preconception arrangements. The justification for so doing is that the harmful activity sought to be prevented by adoption law (financial inducement to part with children) can occur also in preconception arrangements.

The argument that commissioners and carrying women ought to be exempted from penalty for having offered, given, or received money for relinquishing parental rights and duties toward a child is not strong. No one, no matter how great is their suffering from infertility, is entitled in Ontario to offer, give, or receive money for a child. Whilst the Law Reform Commission of Canada is correct to point out that the desire of commissioners to have children is legitimate, the means by which they seek to realize their desire might not be.

37. CFSA, *supra*, note 10, ss. 135 and 176(2).

38. *Ibid.*, s. 159(c).

39. *Supra*, note 10.

40. A ban on advertising exists both in the United Kingdom and in the three Australian states that have legislated on the issue. See Surrogacy Arrangements Act 1985 (U.K.), 1985, c. 49, s. 3; Infertility (Medical Procedures) Act, Victoria, Australia, No. 10163, 1984 s. 30(2)(a); Surrogate Parenthood Act, 1988, Queensland, Australia, No. 65, s. 3(1)(a); and Family Relationships Act Amendment Act, 1988, South Australia, No. 2, s. 10(h)(c).
41. *Supra*, note 10. The unauthorized placements are forbidden by s. 135.
42. *Anna J v. Mark C*, 286 Cal. Rptr. 369 (Cal. App. 4 Dist. 1991).
43. See, generally, S. O'Brien, "The Itinerant Embryo and the Neo-Nativity Scene: Bifurcating Biological Maternity," *Utah Law Review* (1987): 1-33; and G.J. Annas, "Fairy Tales Surrogate Mothers Tell," *Law, Medicine & Health Care* 16 (1-2)(1988): 27-33.
44. For a strong argument for prohibiting embryo transfer in the context of preconception arrangements, see K.H. Rothenberg, "Gestational Surrogacy and the Health Care Provider: Put Part of the 'IVF Genie' Back into the Bottle," *Law, Medicine & Health Care* 18 (1990): 345-52.
45. See the subsection "Who Is the Legal Father?" of "Legal Status of the Parties" in Part 2.
46. CLRA, *supra*, note 30, s. 8(1).
47. *Ibid.* As we saw in Part 2, however, it is not clear that a commissioning man would be successful in attempting to rebut the presumption. His success would ultimately depend upon the court's estimation (in light of the carrying woman's marital status and willingness to relinquish the child) of the child's best interests and the ethical nature of the preconception arrangement. See the subsection "Who Is the Legal Father?" of "Legal Status of the Parties" in Part 2.
48. This is the standard of proof recommended and defended by the NY Task Force, *supra*, note 18, 129-37.
49. See the subsection "Commissioners Described" of "Participants in Preconception Arrangements" in Part 1.
50. See Sullivan, *supra*, note 26, especially at 407-10.
51. See the subsection "Custody Transfer of the Commissioned Child" of "Enforceability of the Provisions of a Preconception Agreement" in Part 2.
52. CLRA, *supra*, note 30, s. 24(2)(a).
53. *Ibid.*, s. 20(4).
54. *Ibid.*, s. 20(5).
55. *Ibid.*, s. 24(1).
56. Family Law Act, *supra*, note 29, s. 31(1).
57. *Richardson v. Richardson* (1987), 7 R.F.L. (3d) 304 at 312 (S.C.C.) per Wilson J.
58. *Ibid.*
59. See the section "Participants in Preconception Arrangements" in Part 1.

60. For an argument that intra-family arrangements are not free from exploitation or harm, see J. Raymond, "Reproductive Gifts and Gift Giving: The Altruistic Woman," *Hastings Center Report* 20 (November-December 1990): 7-11.

Notes to Part 6

1. M. Horsnell and J. Havilland, "Bill to Stamp Out Commercialism: Fowler to Act over Surrogate Births," *The Times* (7 January 1985), 1; *Re C (A Minor) (Wardship: Surrogacy)*, [1985] F.L.R. 846 (U.K. Fam. Div.).
2. See, for example, "Surrogate Mothers," *British Medical Journal* 290 (January 1985), 26.
3. Horsnell and Havilland, *supra*, note 1.
4. S. Sloman, "Surrogacy Arrangements Act, 1985," *New Law Journal* (4 October 1985), 978, fn. 1.
5. Discussed in the subsection "Human Fertilisation and Embryology Act, 1990" in this part, below.
6. Surrogacy Arrangements Act 1985 (U.K.), c. 49, s. 1(2). The Surrogacy Arrangements Act followed the delivery on 26 June 1984 of the government-commissioned *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, Cmnd. 9314 (London: HMSO, 1984) (Chair: Dame Mary Warnock).
7. M. Wright, "Surrogacy and Adoption: Problems and Possibilities," *Family Law* 16 (1986), 110.
8. Surrogacy Arrangements Act, *supra*, note 6, s. 2(1).
9. *Ibid.*, s. 2(3).
10. *Ibid.*, s. 2(4).
11. *Ibid.*, s. 2(5).
12. *Ibid.*, s. 3.
13. *Ibid.*, s. 4.
14. Sloman, *supra*, note 4, 980.
15. (U.K.), 1990, c. 37.
16. The Act establishes an administrative body called the "Human Fertilisation and Embryology Authority" (HFEA) to license such research and infertility treatment. The Act specifically prohibits certain research activities such as trans-species fertilization (s. 4(1)(c)).
17. Section 37(1) now imposes, throughout the United Kingdom, an upper limit of 24 weeks on abortion provided also that the continuation of the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the woman's physical or mental health or that of any of her existing children. It also introduces a new ground for abortion: the procedure is allowed without a time limit where termination of the pregnancy is necessary to prevent grave permanent injury to the physical or mental health of the woman.
18. This subsection (s. 36(1)) came into force on 7 November 1990. HFE Act, SI 1990 No 2165.

19. The amended definition section in the Surrogacy Arrangements Act 1985 now reads:

- 1(2) "Surrogate mother" means a woman who carries a child in pursuance of an arrangement
(a) made before she began to carry the child...
- 1(6) A woman who carries a child is to be treated for the purposes of subsection (2)(a) above as beginning to carry it at the time of the insemination or of the placing in her of an embryo, of an egg in the process of fertilisation or of sperm and eggs, as the case may be.

20. This is prohibited by Surrogacy Arrangements Act 1985, *supra*, note 6, s. 2(1)(a).

21. Prohibited by Surrogacy Arrangements Act, *supra*, note 6, s. 2(5)(b).

22. HUFE Act, *supra*, note 15, ss. 27-29.

23. *Ibid.*, s. 27.

24. This is a complex provision as it creates a new class of children: the legally "fatherless child." Legally fatherless children are those born of artificial insemination by a donor where the donor consented, but the husband refused to consent and he rebuts the common law presumption of legitimacy, or where there is no male partner. A second class of legally fatherless children is created where a woman used thawed sperm after her husband's death. Because death ends the marriage, the child will be born not only "fatherless" but "illegitimate" unless the woman has remarried. D. Morgan, "Human Fertilisation and Embryology Bill: The Status Provisions," *Journal of Social Welfare Law* 2 (1990), 121.

25. Curiously, the House of Lords in its debate on the bill spent "a great deal of time and emotional energy" on the issue of the effect of these provisions on hereditary title. In an attempt to secure the passage of the bill through that House, the government inserted two provisions, s. 29(4) and s. 29(5), which have the effect of ensuring that succession in England, Wales, and Northern Ireland to any dignity or title of honour and property limited to devolve with it will remain through the blood line only. Section 29(5) ensures that Scottish titles will continue to be passed only along blood lines. D. Morgan and R.G. Lee, *Blackstone's Guide to the Human Fertilisation and Embryology Act 1990: Abortion and Embryo Research: The New Law* (London: Blackstone Press, 1991), 160-61.

26. *Ibid.*, 153.

27. This subsection was not broad enough. Had it read "by or on behalf of" the commissioning couple, it would have prevented relatives, friends, and other agents of the commissioning couple from paying the carrying mother to enter and fulfil the terms of a preconception arrangement.

28. *A v. C*, [1985] F.L.R. 445; *Re P (Minors) (Wardship: Surrogacy)*, [1987] 2 F.L.R. 421.

29. See, for example, "Sisters Share Joy of Surrogate Birth," *The Times* (9 June 1988), 9; "Surrogate Mother Will Not Give Up Baby," *The Times* (3 August 1984), 4.

30. C. Ewing, "Draft Report on Surrogacy Issued by the Australian National Bioethics Consultative Committee — The Debate on Surrogacy in Australia Continues," *Reproductive and Genetic Engineering* 3 (1990), 146.
31. The Infertility (Medical Procedures) Act [hereinafter Infertility Act], Victoria, Australia, No. 10163, 1984. This legislation was based on the recommendations of the second and final reports of the Victorian Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, chaired by Professor Louis Waller. The committee examined the issues related to preconception arrangements only as they apply in relation to IVF.
32. Ibid., s. 30(1).
33. Ibid., s. 30(3).
34. Ibid., s. 30(2)(a).
35. Surrogate Parenthood Act, 1988, Queensland, Australia, No. 65. This Act was based, in part, on the recommendations of the special committee appointed by the Queensland government to inquire into laws relating to artificial insemination, IVF, and other related matters (Chair: Mr. Justice Demack). Although the committee recommended that it should not, at least at that time, be made a criminal offence to enter a preconception arrangement, the legislature did not follow that recommendation when it made preconception arrangements criminally illegal.
36. Ibid., s. 3(1)(c).
37. Ibid., s. 3(1)(b).
38. Ibid., s. 3(1)(a).
39. Ibid., s. 3(2).
40. Ibid., s. 4.
41. Family Relationships Act Amendment Act, 1988 [hereinafter Family Relationships Act], South Australia, No. 2. The Select Committee of the South Australia Legislative Council proposed these amendments in its report rendered in 1987. In the *Report on Artificial Insemination by Donor, In-Vitro Fertilisation and Embryo Transfer Procedures and Related Matters in South Australia* (Chair: Hon. John Cornwall MLA), the committee firmly opposed the practice of preconception agreements but did not discuss the reasons for its position. It reaffirmed the legal maternity of the birth mother and recommended that any person organizing a preconception agreement for a fee should be guilty of an offence, and that any such fees paid should be recoverable.
42. Family Relationships Act, s. 10(f).
43. Ibid.
44. Ibid., s. 10(g)(1) and (2).
45. Ibid., s. 10(h)(c).
46. Ibid., s. 10(h)(b).
47. Ibid., s. 10(h)(c).
48. The arguments for the practice included the right to found a family, the decrease in the number of children available for adoption, the practice's therapeutic value in alleviating infertility, and its convenience for the commissioning woman.

49. These included the practice's unacceptable commercial dimension, the contradiction of marriage and procreation by a third party, the potential for exploitation of the carrying woman, the possibility of custody disputes, and the possible introduction of eugenic practices.
50. Committee of Inquiry 1986, *Report of the Committee Appointed by The Western Australian Government to Enquire into the Social, Legal and Ethical Issues Relating to In Vitro Fertilization and Its Supervision* (Chair: Associate Professor C.A. Michael), October 1986.
51. Western Australian Reproductive Technology Working Party 1988, *Report to Minister of Health for Western Australia* (Chair: Mr. M. Daube), August 1988.
52. Select Committee Appointed to Inquire into the Reproductive Technology Working Party's Report, 1988, *Report* (Chair: Dr. Judyth Watson, MLA), Western Australia, December 1988.
53. New South Wales Law Reform Commission, *Artificial Conception: Surrogate Motherhood. Report 3* (Sydney: The Commission, December 1988).
54. Family Law Council, *Creating Children: A Uniform Approach to the Law and Practice of Reproduction Technology in Australia* (Canberra: Australian Government Publishing Service, 1985).
55. *Supra*, note 31.
56. *Supra*, note 35.
57. *Supra*, note 6.
58. National Bioethics Consultative Committee, *Surrogacy: Report 1* (First of Two Reports on Surrogacy. This Report Examines Principles, Options and Recommendations for Australian Health Ministers. Formally Released Pending Consideration by Government), Commonwealth of Australia, April 1990.
59. *Ibid.*, 14-23.
60. *Ibid.*, 36.
61. *Ibid.*, 47-55.
62. The National Bioethics Consultative Committee, *Discussion Paper on Surrogacy 2 — Implementation*, prepared by the working group on Surrogacy 2 for Community Consultation, October 1990.
63. *Ibid.*, 5-6.
64. Resolution of Joint Meeting of Australian Health and Welfare Ministers, March 1991.
65. "The Latest Word," *Hastings Center Report* 21 (May-June 1991), 44.
66. William Whippy, Family and Administrative Law Branch, Commonwealth of Australia Attorney-General's Department, written communication, 25 June 1991.
67. Not included is the legislation in New York. After this report was prepared, the State of New York enacted legislation to make preconception agreements void and unenforceable, and to ban paid arrangements with a fine of up to \$500 and commercial arrangements with a fine up to \$10 000. This legislation is effective on 17 July 1993. See below, note 94.

68. 1989, Ariz. Sess. Laws 14 as published in California, Joint Legislative Committee on Surrogate Parenting, *Commercial and Noncommercial Surrogate Parenting* (Sacramento: Joint Publications Office, 1990), 30-31 [hereinafter California Joint Committee].
69. Ky. Rev. Stat. Sec. 199.590 (1988). California Joint Committee, *supra*, note 68, 44.
70. Mich. Comp. Laws Sec. 722.851-722.863 (1988). California Joint Committee, *supra*, note 68, 25, 46-47.
71. 1989 Utah Laws 140. California Joint Committee, *supra*, note 68, 26 and 71.
72. 1989 Wash. Laws 404. California Joint Committee, *supra*, note 68, 26, 72-73.
73. The Utah statute was to operate only until July 1991, but on 19 March 1991 the state governor passed legislation repealing that sunset provision.
74. The statute also prohibited participation in, or brokerage of, an agreement (paid or unpaid) whereby the carrying woman would be under 18 years of age, mentally retarded, mentally ill, or developmentally disabled. The penalty for participation in or brokerage of such an arrangement was \$50 000, five years' imprisonment, or both.
75. Noel Keane operates brokerage agencies in Dearborn, Michigan, New York City, Indianapolis, and a suburb of San Francisco. See the subsection "Brokers" of "Participants in Preconception Arrangements" in Part 1.
76. Brief of the Attorney General of Michigan, "Motion for Summary Disposition" in *Jane Doe et al. v. A.G. Michigan*, Docket No. 88-819032-C2, Wayne County Circuit Court, 9 September 1988.
77. "Surrogacy: A Way Can Be Found to Be Sensitive to All Parties," *Detroit Free Press* (22 September 1988), 10A; California Joint Committee, *supra*, note 68, 25.
78. La. Rev. Stat. Ann. Sec. 9:2713 (1987). California Joint Committee, *supra*, note 68, 25 and 45.
79. Ne. Rev. Stat. 674 (1988). California Joint Committee, *supra*, note 68, 48.
80. Ind. Code Sec. 31-8-2-1 to 31-8-2-3 (1988). California Joint Committee, *supra*, note 68, 24, 43.
81. 1989 N.D. Sess. Laws 184. California Joint Committee, *supra*, note 68, 26, 69-70.
82. 1989 Ark. Acts 647. California Joint Committee, *supra*, note 68, 23, 32-33.
83. Fla. Sta. Sec. 63.212(1) (1988). California Joint Committee, *supra*, note 68, 36-41.
84. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, 50-68.
85. Fla. Sta. Sec. 63.212(1)(1988). California Joint Committee, *supra*, note 68, Sec. 63.212(1) 2f.
86. See the subsection "A More Complete Picture of Supply" of "Analysis of Supply" in Part 3.
87. (1990) N.H. Law 87. California Joint Committee, *supra*, note 68, 50-68.
88. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, preamble.

89. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, Sec. 168-B:16IV.
90. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, Sec. 168-B:25V.
91. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, Sec. 168-B:18II.
92. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, Sec. 168-B:25, "Mandatory Terms of Surrogacy Contract."
93. 1990 N.H. Law 87. California Joint Committee, *supra*, note 68, Sec. 168-B:27.
94. After this report was prepared, New York passed legislation effective 17 July 1993 that made paid and commercial arrangements illegal, rendered all others unenforceable, and stated that the woman who gives birth is the "birth mother" without specifically addressing who, as between the birth mother and the ovum provider in exclusively gestational arrangements, should be considered the legal mother. N.Y., Domestic Relations Law c. 308, Article 8, Sec. 121-124, 192.
95. Staff of the New York State Senate Judiciary Committee, John R. Dunne, Chairman, *Surrogate Parenting in New York: A Proposal for Legislative Reform* (Albany: The Senate of the State of New York, January 1987) [hereinafter Dunne Report].
96. See the section "Legislative Policy Based on a Growth Perspective and Family Law" in Part 5.
97. Dunne Report, *supra*, note 95, 49.
98. *Ibid.*, 22.
99. *Ibid.*, 15.
100. New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (Albany: 1988), iii.
101. *Ibid.*, A-2.
102. *Ibid.*, 136-37.
103. *Ibid.*, iv.
104. California Joint Committee, *supra*, note 68.
105. Professor Vicki Michel, Presentation of Advisory Panel Report, California Joint Committee, *supra*, note 68, 9-14.
106. Quebec Civil Code, S.Q. 1991, c. 64, introduced 18 December 1990, passage in principle 4 June 1991, assented to 18 December 1991. As of 7 April 1993, this bill had not been proclaimed and was, therefore, not in force, though a further bill to implement Bill 125 was assented to on 18 December 1992.
107. See the subsection "Incidence" of "Canada" in Part 1.
108. After the completion of this study, the Law Reform Commission of Canada published its report entitled, *Medically Assisted Procreation*, in which it recommended that "Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence." Law Reform Commission of Canada, *Medically Assisted Procreation*, Working Paper 65 (Ottawa: LRC, 1992), 138.

109. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985).
110. See the subsection "The Argument of Medical Necessity" of "A Consideration of Proponents' Arguments" in Part 4.
111. See Appendix 2, "Analysis of the Ontario Law Reform Commission's Arguments Regarding Preconception Arrangements."

Notes to Part 7

1. See Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985), 36-39 [hereinafter OLRC]; and R.J. Cook, "New Reproductive Technologies: International Legal Issues and Instruments," in *Overview of Legal Issues in New Reproductive Technologies*, vol. 3 of the research studies of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Government Services Canada, 1993).
2. United Nations General Assembly, "Universal Declaration of Human Rights," in *Basic Documents on Human Rights*, ed. I. Brownlie (Oxford: Clarendon Press, 1971) [hereinafter Universal Declaration].
3. P. Sieghart, *The International Law of Human Rights* (Oxford: Clarendon Press, 1983), 24.
4. Universal Declaration, *supra*, note 2, 107.
5. *Ibid.*, 109-10.
6. United Nations General Assembly, "Declaration of the Rights of the Child," in Brownlie, *supra*, note 2 [hereinafter Declaration of the Rights of the Child].
7. "Measures to Assist the Most Vulnerable Groups," in *United Nations Action in the Field of Human Rights* (New York: United Nations, 1983), 206.
8. Declaration of the Rights of the Child, *supra*, note 6, 188-89.
9. *Ibid.*, 189.
10. *Ibid.*, 189-90.
11. Although adoption does this too, it is an arrangement made by the mother after she gives birth and because she believes she is unable to care for the child. Statutory regimes governing adoption are predicated on the best interests of the child.
12. United Nations General Assembly, "International Covenant on Economic, Social and Cultural Rights" [adopted 16 December 1966], in Brownlie, *supra*, note 2, 199 [hereinafter ESC Covenant].
13. United Nations General Assembly, "International Covenant on Civil and Political Rights" [adopted 16 December 1966], in Brownlie, *supra*, note 2, 211 [hereinafter Civil and Political Covenant].
14. United Nations General Assembly, "Optional Protocol to the International Covenant on Civil and Political Rights" [adopted 16 December 1966], in Brownlie, *supra*, note 2, 232 [hereinafter Optional Protocol].
15. ESC Covenant, *supra*, note 12, 199.

16. *Ibid.*, 200.
17. *Ibid.*, 205-206.
18. This was the position of the OLRC, *supra*, note 1, 37.
19. ESC Covenant, *supra*, note 12, 203.
20. *Ibid.*
21. Civil and Political Covenant, *supra*, note 13, 212.
22. *Ibid.*, 218.
23. *Ibid.*, 220.
24. *Ibid.*, 214.
25. *Ibid.*, 220.
26. Optional Protocol, Articles 1 and 2, *supra*, note 14, 232-33.
27. "United Nations Convention on the Rights of the Child," in *Children's Rights in America: U.N. Convention on the Rights of the Child Compared with United States Law*, ed. C.P. Cohen and H.A. Davidson (Chicago: American Bar Association Center on Children and the Law, 1990), xi.

Notes to Part 8

1. The *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982 (being Schedule B of the Canada Act 1982 (U.K.) 1982, c. 11) [hereinafter Charter]. I am indebted to Marc Gold and Bruce Ryder for the analytic framework, which I have expanded and made more current, on which this chapter is based. M. Gold and B. Ryder, "The Charter and the Regulation of Reproductive Technology," A Draft Working Paper on Medically Assisted Procreation for the Law Reform Commission of Canada, now published in Law Reform Commission of Canada, *Medically Assisted Procreation*, Working Paper 65 (Ottawa: LRC, 1992).
2. This analysis does not include consideration of the constitutional division of powers.
3. Charter, *supra*, note 1, s. 32.
4. *Retail, Wholesale and Department Store Union, Local 580 v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573. This case does not completely exclude the application of the Charter to private law relations; the Charter applies "where such exercise of, or reliance upon, governmental action is present and where one private party invokes or relies upon it to produce an infringement of the Charter rights of another" at 602-603 per McIntyre J. See also *Borowski v. Canada (A.G.)*, [1989] 1 S.C.R. 342; *Tremblay v. Daigle*, [1989] 2 S.C.R. 530.
5. *Re Bhindi and British Columbia Projectionists* (1986), 29 D.L.R. (4th) 47 (B.C.C.A.); leave to appeal refused [1986] 2 S.C.R. v.
6. *Re Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, (1985) 17 D.L.R. (4th) 422 at 464 [hereinafter *Re Singh* cited to D.L.R.].
7. *Ibid.*, 458 per Wilson J.
8. *Ibid.*, 458-59 per Wilson J.

9. *Reference Re Section 94(2) of the Motor Vehicle Act, R.S.B.C. 1979, c. 288*, [1985] 2 S.C.R. 486, [1986] 1 W.W.R. 481 (S.C.C.) [hereinafter *Motor Vehicle Reference* cited to W.W.R.]; *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code* (1990), 56 C.C.C. (3d) 65 (S.C.C.) [hereinafter the *Prostitution Reference*].
10. *R. v. Jones*, [1986] 2 S.C.R. 284, [1986] 6 W.W.R. 577 [hereinafter *Jones* cited to W.W.R.].
11. *Ibid.*, 591.
12. *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385 [hereinafter *Morgentaler* cited to D.L.R.].
13. *Ibid.*, 486.
14. *Ibid.*
15. *Ibid.*, 487.
16. *Supra*, note 9.
17. *Ibid.*, 103.
18. *Re Singh*, *supra*, note 6, 459.
19. *Ibid.*, 460.
20. *Morgentaler*, *supra*, note 12, 401.
21. *Ibid.*, 427.
22. See the subsection "The Argument of Medical Necessity" of "A Consideration of Proponents' Arguments" in Part 4.
23. *Morgentaler*, *supra*, note 12, 492.
24. *Motor Vehicle Reference*, *supra*, note 9.
25. *Re Singh*, *supra*, note 6, 464 per Wilson J. quoting Fauteux C.J.C. in *Duke v. R.* (1972), 28 D.L.R. (3d) 129.
26. *Motor Vehicle Reference*, *supra*, note 9, 496 per Lamer J.
27. *Jones*, *supra*, note 10, 606. See also Dickson C.J. in *Morgentaler*, *supra*, note 12, 414.
28. *R. v. Beare*, [1988] 2 S.C.R. 387.
29. *Motor Vehicle Reference*, *supra*, note 9, 495-96 per Lamer J.
30. *Ibid.*, 504-505 per Lamer J. quoting Professor Tremblay, in *U.B.C. Law Review* 18 (1984), 254.
31. In *Children's Aid Society of Halifax v. G.H.* (1989), 85 N.S.R. (2d) 286 (Fam. Ct.), the Society apprehended a child in need of protection and sought an order to place the child in the care and custody of the Society. The mother pleaded that the Children's Services Act, S.N.S. 1976, which permitted the granting of such an order, violated, *inter alia*, her s. 7 right. The court held that s. 7 is applicable to protecting a child who might be in need of protection and has no application to the parents of a child. In *Re C.P.L.* (1988), 70 Nfld. & P.E.I.R. 287 (Nfld. U.F.C.), the Child Welfare Act, S.N. 1972, c. 37, which permitted the Director of Child Welfare to apprehend a child without notice to the parents, was challenged on the basis of the parents' s. 7 right. The court stated it was not sure that there exists a right to family

autonomy under the Charter. The parental rights to their children were outnumbered by their obligations. The judge stated he was "only concerned with the right to life, liberty and security of the child" (at 303). Similarly, in *Re T and Catholic Children's Aid Society of Metropolitan Toronto* (1984), 46 O.R. (2d) 347 (Prov. Ct.), even though the judge accepted that "security of the person includes the right to individual privacy or family autonomy ... and that one of the liberty interests to be protected is the parental right to be free from State intervention," he did not find that the statute permitting the Children's Aid Society to obtain an *ex parte* order to bring forward a child allegedly in need of protection violated s. 7. Although the parents' security or liberty interests had been affected, the interests of the child, who is also protected by s. 7, were more determinative, at 357-58. Finally, in *Children's Aid Society of Hamilton-Wentworth v. K. (L.)* (1989), 70 O.R. (2d) 466 (U.F.C.), the court did not recognize the right of a parent under s. 7 to raise a child when the court considered that the exercise of that right was not in the best interests of the child. Thus, a child with numerous and serious medical problems was permitted to become a Crown ward even though the order would diminish the parents' rights. The court held (at 482)

the right of a parent to raise his child, which is now subordinate to the best interests of the child, and which derives, even from our earliest history, from the duty on the part of the parent to properly raise him, is not a liberty interest intended to be protected by s. 7 of the Charter.

32. *Catholic Children's Aid Society of Metropolitan Toronto v. S. (T.)* (1989), 60 D.L.R. (4th) 397 (Ont. C.A.).
33. *Ibid.*, 412.
34. *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, (1989) 56 D.L.R. (4th) 1 [hereinafter *Andrews* cited to D.L.R.].
35. R.M. Dworkin, *Taking Rights Seriously* (Cambridge: Harvard University Press, 1978).
36. *Andrews, supra*, note 34, 11 per McIntyre J.
37. *R. v. Turpin*, [1989] 1 S.C.R. 1296, (1989) 48 C.C.C. (3d) 8 at 32 per Wilson J. [hereinafter *Turpin* cited to C.C.C.].
38. *Andrews, supra*, note 34, 18 per McIntyre J.
39. *Ibid.*, 24.
40. *Ibid.*, 18.
41. *Ibid.*, 32 per Wilson J.
42. M.D. Lepofsky, "Equality and Disabled Persons," in *Justice Beyond Orwell*, ed. R.S. Abella and M.L. Rothman (Montreal: Éditions Yvon Blais, 1985), 313.
43. M.D. Lepofsky and J.E. Bickenbach, "Equality Rights and the Physically Handicapped," in *Equality Rights and the Canadian Charter of Rights and Freedoms*, ed. A. Bayefsky and M. Ebets (Toronto: Carswell, 1985), 348.
44. See the subsection "Commissioners" of "Participants in Preconception Arrangements" in Part 1.
45. See B. Ryder, "Equality Rights and Sexual Orientation: Confronting Heterosexual Family Privilege," *Canadian Journal of Family Law* 9 (1990-91): 39-97.

46. *Irwin Toy Ltd. v. Quebec* (A.G.), [1989] 1 S.C.R. 927, (1989) 58 D.L.R. (4th) 577 [hereinafter *Irwin Toy* cited to D.L.R.].
47. *Ibid.*, 607.
48. *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712, (1988) 54 D.L.R. (4th) 577 at 619.
49. *Rocket v. Royal College of Dental Surgeons of Ontario*, [1990] 2 S.C.R. 232, (1990) 71 D.L.R. (4th) 68 at 77 per McLachlin J.
50. *R. v. Therens*, [1985] 1 S.C.R., 613, (1985) 18 D.L.R. (4th) 655.
51. *Irwin Toy*, *supra*, note 46, 617.
52. *R. v. Oakes*, [1986] 1 S.C.R. 103, (1986) 26 D.L.R. (4th) 200.
53. This is the second part of the *Oakes* test as summarized by Lamer J. in *R. v. Chaulk* (1990), 2 C.R. (4th) 1 at 27-28.
54. See J. Cameron, "The Original Conception of Section 1 and Its Demise: A Comment on *Irwin Toy Ltd. v. Attorney-General of Quebec*," *McGill Law Journal* 35 (1990), 261. See also D. Stuart, "Will Section 1 Now Save Any Charter Violation? The Chaulk Effectiveness Test Is Improper," *C.R.* (4th) 2 (1991): 107-17; M. Gold, "Of Rights and Roles: The Supreme Court and the Charter," *U.B.C. Law Review* 23 (1989), 521; P.G. Murray, "Section One of the Canadian Charter of Rights and Freedoms: An Examination of Two Levels of Interpretation," *Ottawa Law Review* 21 (1989), 677; and P.W. Hogg, "Interpreting the Charter of Rights: Generosity and Justification," *Osgoode Hall Law Journal* 28 (1990), 819.
55. *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, (1986) 35 D.L.R. (4th) 1 [hereinafter *Edwards Books* cited to D.L.R.].
56. *Irwin Toy*, *supra*, note 46.
57. *Edwards Books*, *supra*, note 55, 48.
58. *Ibid.*, 49.
59. *Irwin Toy*, *supra*, note 46, 625.

Notes to Appendix 1

1. *In the Matter of Baby "M."* 525 A. 2d 1128 (N.J. Super. Ch. 1987).
2. J.A. Robertson, "Procreative Liberty: The Control of Conception, Pregnancy, and Childbirth," *Virginia Law Review* 69 (1983), 406.
3. 316 U.S. 535 (1942) at 541.
4. *Ibid.*
5. *Loving v. Virginia*, 388 U.S. 1 (1967).
6. *Zablocki v. Redhail*, 434 U.S. 374 (1978).
7. *Ibid.*, 384.
8. See L.D. Wardle et al., "Creating Family Relations," in *Contemporary Family Law*, Vol. 1 (Deerfield: Callaghan and Company, 1989), section 2.
9. 262 U.S. 390 (1923).
10. *Ibid.*, 399 per McReynolds J.

11. 268 U.S. 510 (1924).
12. *Ibid.*
13. 405 U.S. 645 (1972).
14. *Quilloin v. Walcott*, 434 U.S. 246 (1978).
15. *Skinner v. Oklahoma*, *supra*, note 3.
16. *Loving v. Virginia*, *supra*, note 5.
17. *Zablocki v. Redhail*, *supra*, note 6.
18. See *Wardle*, *supra*, note 8.
19. See *Bowers v. Hardwick*, 478 U.S. 186 (1986) (refusing to recognize a fundamental privacy right to engage in sodomy).
20. See *Wardle*, *supra*, note 8.
21. *Meyer v. Nebraska*, *supra*, note 9.
22. *Stanley v. Illinois*, *supra*, note 13; and *Quilloin v. Walcott*, *supra*, note 14.
23. *Griswold v. Connecticut*, 381 U.S. 479 (1965).
24. *Ibid.*, 493 per Goldberg J.
25. 405 U.S. 438 (1972).
26. *Ibid.*, 453.
27. See, for example, *Robertson*, *supra*, note 2.
28. The Court was confronted with the question of access to contraception a third time when the issue was whether access could be denied to minors. In *Carey v. Population Services International*, 431 U.S. 678 (1977), the Court held that the state could not deny access to contraception because the legislation served no compelling state interest, and it was not drafted sufficiently narrowly to achieve a legitimate purpose.
29. *Roe v. Wade*, 410 U.S. 113 (1973) at 153 per Blackmun J. In *Roe v. Wade*, the Court held that because the woman's right to decide whether to end a pregnancy is fundamental, only a compelling interest could justify state regulation impinging in any way upon that right. During the first trimester of pregnancy the state may require only that the abortion be performed by a licensed physician. After the first trimester, the compelling state interest in the mother's health permits it to adopt reasonable regulations to promote safe abortions. Once the fetus is viable, in the sense that it can survive outside the woman's body with artificial aid, the state interest in preserving the fetus becomes compelling. L.H. Tribe, *American Constitutional Law*, 2d ed. (Mineola: Foundation Press, 1988), 1341-42.
30. Since the *Roe v. Wade* decision, the Supreme Court has struck down legislation that would limit a woman's exercise of the privacy right recognized in *Roe v. Wade*. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Thornborough v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).
31. See B. Kritchevsky, "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family," *Harvard Women's Law Journal* 4 (1981): 1-42; *Robertson*, *supra*, note 2, 405; J.A. Robertson, "Embryos, Families,

- and Procreative Liberty: The Legal Structure of the New Reproduction," *Southern California Law Review* 59 (1986): 939-1041; J.A. Robertson, "Procreative Liberty, Embryos, and Collaborative Reproduction: A Legal Perspective," *Women and Health* 13 (1987): 179-94; J.A. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction," *Law, Medicine & Health Care* 16 (1-2)(1988), 24; J.A. Robertson, "Decisional Authority over Embryos and Control of IVF Technology," *Jurimetrics* 28 (1988): 285-304; J.A. Robertson, "Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation," *Case Western Reserve Law Review* 39 (1988-89): 1-38; C. Rushevsky, "Legal Recognition of Surrogate Gestation," *Women's Rights Law Reporter* 7 (1982): 107-42; and A.E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies," *Yale Law Journal* 96 (1986): 187-208.
32. Robertson, "Procreative Liberty, Embryos, and Collaborative Reproduction," *supra*, note 31, 180.
33. *Supra*, note 1.
34. *Supra*, note 1, 1165, quoting J.A. Robertson, "Surrogate Mothers: Not So Novel After All," *Hastings Center Report* 13 (October 1983): 28-34.
35. Rushevsky, *supra*, note 31.

Notes to Appendix 2

1. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985) [hereinafter OLRC].
2. The members of the commission were James R. Breithaupt, H. Allan Leal, Richard A. Bell, William R. Poole, and Barry A. Percival, each a lawyer and Queen's Counsel.
3. Allan Leal wrote a separate dissenting report, "Vice Chairman's Dissent." He recommended the prohibition of preconception arrangements as being contrary to public policy. OLRC, *supra*, note 1, 287-91.
4. *Ibid.*, 230.
5. *Ibid.*
6. *Ibid.*, 231.
7. *Ibid.*, 255.
8. *Ibid.*
9. *Ibid.*, 289-90.
10. *Ibid.*, 231.
11. *Ibid.*
12. *Ibid.*
13. See, for example, R. Winkler and M. van Keppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment* (Melbourne: Institute of Family Studies, 1984).
14. See the subsection "Harm to the Carrying Woman" of "Harm and Potential Harm of the Practice" in Part 3.

15. See the subsection "Harm to the Commissioned Child" of "Harm and Potential Harm of the Practice" in Part 3.
16. OLRC, *supra*, note 1, 231.
17. *Ibid.*, 242.
18. *Ibid.*, 255.
19. *Ibid.*, 232.
20. See, for example, "Birth Announcements," SBC [Surrogates by Choice] Newsletter (Spring 1988), in M. Eichler and P. Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians*, report prepared for the Law Reform Commission of Canada (Toronto: Ontario Institute for Studies in Education, 1988), Appendix 8.
21. OLRC, *supra*, note 1, 237.
22. *Ibid.*
23. This argument has been addressed in the subsection "The Argument of Medical Necessity" of "A Consideration of Proponents' Arguments" in Part 4.
24. OLRC, *supra*, note 1, 259.
25. Commissioning couples have in fact divorced, and in at least two cases the carrying woman has intervened in the divorce action to seek custody. See the section "Analysis of Demand" in Part 3.
26. OLRC, *supra*, note 1, 176.
27. "Recommendation 22(4). Anonymity concerning the identity of all parties involved in artificial conception — the donor, the recipient, her spouse or partner (if any), and the child — should be preserved in the medical records." *Ibid.*, 279.
28. *Ibid.*, 240.
29. *Ibid.*
30. *Ibid.*
31. It is interesting that the majority should suggest that counsel for the prospective commissioning parents would submit medical information regarding the carrying woman.
32. OLRC, *supra*, note 1, 240.
33. *Ibid.*
34. *Ibid.* With one exception: women under 18 years of age.
35. *Ibid.*, 242.
36. *Ibid.*
37. *Ibid.*, 231.
38. The OLRC instead recommended specific performance of all approved preconception agreements, as is discussed below.
39. OLRC, *supra*, note 1, 246.
40. *Ibid.*, 248.
41. *Ibid.*, 250.

42. Ibid.
43. Ibid., 251.
44. Ibid., 252.
45. Ibid.
46. Ibid., 253.
47. The OLRC report was written before the decision of the Supreme Court in *R. v. Morgentaler*, [1988] 1 S.C.R. 30.
48. OLRC, *supra*, note 1, 259.
49. As a practical matter, the child's rights to inherit from its mother would seem a moot point. As we have seen, women who agree to become carrying women do not have a great deal of money and are unlikely to leave much, if any, to their offspring. See the section "Analysis of Supply" in Part 3.
50. OLRC, *supra*, note 1, 262.
51. Ibid., 263.
52. Ibid., 265.
53. See the section "Participants in Preconception Arrangements" in Part 1.
54. OLRC, *supra*, note 1, 271.

Selected Bibliography

Books, Articles, Reports

- Adair, P. *A Surrogate Mother's Story*. Toronto: Paperjacks, 1988.
- American Bar Association. Section of Family Law. "Draft ABA Model Surrogacy Act." *Family Law Quarterly* 22 (1988): 123-43.
- American Fertility Society. Ethics Committee. "Ethical Considerations of the New Reproductive Technologies." *Fertility and Sterility* 53 (Suppl. 2) (1990).
- Anderson, D. "The Emotional Impact of Miscarriage." M.Ed. thesis, Ontario Institute for Studies in Education, 1987.
- Anderson, E. "The Ethical Limitations of the Market." *Economics and Philosophy* 6 (1990): 179-205.
- Andrews, L.B. "Alternative Modes of Reproduction." In *Reproductive Laws for the 1990s*, ed. S. Cohen and N. Taub. Clifton: Humana Press, 1989.
- . *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies*. New York: Harper and Row, 1989.
- . "Surrogate Motherhood: Should the Adoption Model Apply?" *Children's Legal Rights Journal* 7 (1987): 13-20.
- . "Surrogate Motherhood: The Challenge for Feminists." *Law, Medicine & Health Care* 16 (1-2)(1988): 72-80.

- . "Surrogate Motherhood: The Challenge for Feminists." In *Surrogate Motherhood: Politics and Privacy*, ed. L. Gostin. Bloomington: Indiana University Press, 1990.
 - . "When Should You Use a Surrogate Mother." In *New Conceptions: A Consumer's Guide to the Newest Infertility Treatment Including In Vitro Fertilization, Artificial Insemination, and Surrogate Motherhood*. New York: St. Martin's Press, 1984.
- Annas, G.J. "Fairy Tales Surrogate Mothers Tell." *Law, Medicine & Health Care* 16 (1-2)(1988): 27-33.
- Arditti, R. "The Surrogacy Business." *Social Policy* 18 (1987): 42-46.
- . "Wombs for Rent, Babies for Sale." *Sojourner* (March 1987): 10 et seq.
- Australia. National Bioethics Consultative Committee. *Discussion Paper on Surrogacy 2 — Implementation*. Canberra: 1990.
- . *Surrogacy: Report 1*. Canberra: 1990.
- Australia. New South Wales Law Reform Commission. *Artificial Conception: Discussion Paper 3, Surrogate Motherhood*. Sydney: The Commission, 1988.
- . *Artificial Conception: Surrogate Motherhood, Report 3*. Sydney: The Commission, 1988.
- Australia. South Australia. Select Committee of the South Australia Legislative Council. *Report on Artificial Insemination by Donor, In-Vitro Fertilisation and Embryo Transfer Procedures and Related Matters in South Australia*. Adelaide: 1987 (Chair: Hon. John Cornwall, MLA).
- Australia. Western Australia. Committee of Inquiry. *Report of the Committee Appointed by the Western Australian Government to Enquire into the Social, Legal and Ethical Issues Relating to In Vitro Fertilization and Its Supervision*. Perth: 1986 (Chair: Associate Professor C.A. Michael).
- Australia. Western Australia. Reproductive Technology Working Party 1988. *Report to Minister of Health for Western Australia*. Perth: 1988 (Chair: Mr. M. Daube).
- Australia. Western Australia. Select Committee Appointed to Inquire into the Reproductive Technology Working Party's Report, 1988. *Report*. Perth: 1988 (Chair: Dr. Judyth Watson, MLA).
- Bartels, D.M. "Surrogacy Arrangements: An Overview." In *Beyond Baby M*, ed. D. Bartels et al. Clifton: Humana Press, 1989.
- Boyd, S. "From Gender Specificity to Gender Neutrality? Ideologies in Canadian Custody Law." In *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen. London: Routledge, 1989.
- Brophy, K.M. "A Surrogate Mother Contract to Bear a Child." *Journal of Family Law* 20 (1981-82): 263-91.
- California. Joint Legislative Committee on Surrogate Parenting. "Majority Report to the California Legislature." In *Commercial and Non-Commercial Surrogate Parenting*. Sacramento: Joint Publications Office, 1990.

- Cameron, J. "The Original Conception of Section 1 and Its Demise: A Comment on *Irwin Toy Ltd. v. Attorney-General of Quebec*." *McGill Law Journal* 35 (1990): 253-77.
- Capron, A.M. "Alternative Birth Technologies: Legal Challenges." *U.C. Davis Law Review* 20 (1987): 679-704.
- . "Whose Child Is This?" *Hastings Center Report* 21 (November-December 1991): 37-38.
- Capron, A.M., and M.J. Radin. "Choosing Family Law over Contract Law as a Paradigm for Surrogate Motherhood." *Law, Medicine & Health Care* 16 (1-2)(1988): 34-43.
- Chesler, P. *Sacred Bond: The Legacy of Baby M*. New York: Times Books, 1988.
- Children's Aid Society of Metropolitan Toronto. "Adoption Today." *Our Children* 14 (Winter 1979): 5.
- . *Annual Report, 1985*. Toronto: 1986.
- Christopher, R. "A Judgment for Solomon." *Maclean's* 94 (6 April 1981): 33.
- Colarusso, C.A. "Mother, Is That You?" *Psychoanalytic Study of the Child* 42 (1987): 223-37.
- Condon, J.T. "Psychological Disability in Women Who Relinquish a Baby for Adoption." *Medical Journal of Australia* 144 (1986): 117-19.
- Cook, R.J. "New Reproductive Technologies: International Legal Issues and Instruments." In *Overview of Legal Issues in New Reproductive Technologies*, vol. 3 of the research studies of the Royal Commission on New Reproductive Technologies. Ottawa: Minister of Government Services Canada, 1993.
- Corea, G. "Industrial Experimentation on 'Surrogate' Mothers." In *Reconstructing Babylon: Essays on Women and Technology*, ed. H.P. Hynes. Bloomington: Indiana University Press, 1991.
- . "Junk Liberty." In *Reconstructing Babylon: Essays on Women and Technology*, ed. H.P. Hynes. Bloomington: Indiana University Press, 1991.
- . "Junk Liberty." In *Surrogate Motherhood: Politics and Privacy*, ed. L. Gostin. Bloomington: Indiana University Press, 1990.
- . *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper and Row, 1985.
- Dahlman, C.J. "The Problem of Externality." *Journal of Law and Economics* 22 (1979): 141-62.
- Deykin, E.Y., L. Campbell, and P. Patti. "The Postadoption Experience of Surrendering Parents." *American Journal of Orthopsychiatry* 54 (1984): 271-80.
- Dickens, B.M. "Artificial Reproduction and Child Custody." *Canadian Bar Review* 66 (1987): 49-75.
- . "Enforcement of Surrogate Motherhood Agreements." *Transplantation Today* 4 (May 1987): 17.
- . "Legal Aspects of Surrogate Motherhood: Practices and Proposals." Paper presented at the U.K. National Committee of Comparative Law 1987

- Colloquium, "Legal Regulation of Reproductive Medicine," Girton College, Cambridge, England, 15-17 September 1987.
- . "Surrogate Motherhood: Legal and Legislative Issues." In *Genetics and the Law III*, ed. A. Milunsky and G.J. Annas. New York: Plenum Press, 1985.
- Dixon, K.M., et al. "A Case of Surrogate Pregnancy." *Journal of Family Practice* 30 (1990): 19-26.
- Downie, S. *Babymaking: The Technology and the Ethics*. London: Bodley Head, 1988.
- Dworkin, R.M. *Taking Rights Seriously*. Cambridge: Harvard University Press, 1978.
- Eichler, M., and P. Poole. *The Incidence of Preconception Contracts for the Production of Children Among Canadians*. Report prepared for the Law Reform Commission of Canada. Toronto: Ontario Institute for Studies in Education, 1988.
- "Enforceability Needed for Surrogate Parents' Agreements." *Lawyers Weekly* (20 June 1986): 12.
- Ewing, C. "Draft Report on Surrogacy Issued by the Australian National Bioethics Consultative Committee — The Debate on Surrogacy in Australia Continues." *Reproductive and Genetic Engineering* 3 (1990): 143-46.
- Family Law Council. *Creating Children: A Uniform Approach to the Law and Practice of Reproduction Technology in Australia*. Canberra: Australian Government Publishing Service, 1985.
- Field, M.A. *Surrogate Motherhood*. Cambridge: Harvard University Press, 1988.
- Frank, D., and M. Vogel. *The Baby Makers*. New York: Carroll and Graf, 1988.
- Franklin, U.M. *The Real World of Technology*. CBC Massey Lectures Series. Toronto: CBC Enterprises, 1990.
- Frederick, W.R., et al. "HIV Testing of Surrogate Mothers." *New England Journal of Medicine* 317 (1987): 1351-52.
- Freeman, M. "Is Surrogacy Exploitative?" In *Legal Issues in Human Reproduction*, ed. S. McLean. Aldershot: Gower Publishing, 1989.
- Garcia, J. "Return to the Natural Cycle for In Vitro Fertilization (Alleluia! Alleluia!)." *Journal of In Vitro Fertilization and Embryo Transfer* 62 (1989): 67-68.
- Garrison, M. "Surrogate Parenting: What Should Legislatures Do?" *Family Law Quarterly* 22 (1988): 149-72.
- Gladwell, M., and R. Sharpe. "Baby M Winner: Meet the Surrogacy Entrepreneur." *New Republic* (16 February 1987): 15-18.
- Gold, M. "Of Rights and Roles: The Supreme Court and the Charter." *U.B.C. Law Review* 23 (1989): 507-30.
- Gostin, L. "A Civil Liberties Analysis of Surrogacy Arrangements." *Law, Medicine & Health Care* 16 (1-2)(1988): 7-17.
- Gradstein, B.D., M. Gradstein, and R.H. Glass. "Private Adoption." *Fertility and Sterility* 37 (1982): 548-51.

- Greengross, W., and D. Davies. "Expression of Dissent: Surrogacy." In M. Warnock, *A Question of Life: The Warnock Report on Human Fertilisation and Embryology*. Oxford: Basil Blackwell, 1985.
- Guest, A.G., ed. *Anson's Law of Contract*. 26th ed. Oxford: Clarendon Press, 1984.
- Handel, W., and H. Hanafin. "Success Rate of Surrogate Gestational Pregnancies Using In Vitro Fertilization Donor Oocytes." In *Advances in Assisted Reproductive Technologies*, ed. M. Shlomo et al. New York: Plenum Press, 1990.
- Hogg, P.W. "Interpreting the Charter of Rights: Generosity and Justification." *Osgoode Hall Law Journal* 28 (1990): 817-38.
- Humphrey, M., and H. Humphrey. "A Fresh Look at Genealogical Bewilderment." *British Journal of Medical Psychology* 59 (1986): 133.
- Ignatieff, M. "All Shook Up: The Self and Its Crisis — Lecture 3: Love." Larkin Stuart Lectures, Trinity College, Toronto, 10 November 1988.
- Ince, S. "Inside the Surrogate Industry." In *Test-Tube Women: What Future for Motherhood?* ed. R. Arditti, R.D. Klein, and S. Minden. London: Pandora Press, 1989.
- "Interview with John A. Robertson: Life, Liberty and Children." *ABA Journal* 73 (1 June 1987): 39.
- Kane, E. *Birth Mother*. San Diego: Harcourt Brace Jovanovich, 1988.
- . "Surrogate Parenting: A Division of Families, Not a Creation." *Reproductive and Genetic Engineering* 2 (1989): 105-109.
- Katz, S. "The New Reproductive Era: Doctors Will Face New Ethical Challenges." *Canadian Medical Association Journal* 136 (1987): 1293-94.
- Keane, N.P. "Attorney-Client Agreement, 1988, Exhibit 'A': Statement of Charges Incident to the Surrogate Service." Dearborn: 1988.
- . "Surrogate Parenting Agreement." Dearborn: 1988.
- Keane, N.P., with D.L. Breo. *The Surrogate Mother*. New York: Everest House, 1981.
- Kopecky, G. "Wombs for Hire." *Omni* 5 (June 1988): 18.
- Kritchevsky, K. "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family." *Harvard Women's Law Journal* 4 (1981): 1-42.
- La Puma, J., D. Schiedermayer, and J. Grover. "Surrogacy and Shakespeare: The Merchant's Contract Revisited." *American Journal of Obstetrics and Gynecology* 160 (1989): 59-62.
- Lasker, J.N., and S. Borg. *In Search of Parenthood: Coping with Infertility and High-Tech Conception*. Boston: Beacon Press, 1987.
- Law Reform Commission of Canada. *Medically Assisted Procreation*. Working Paper 65. Ottawa: LRC, 1992.
- Leeton, J., C. King, and J. Harman. "Sister-Sister In Vitro Fertilization Surrogate Pregnancy with Donor Sperm: The Case for Surrogate Gestational Pregnancy." *Journal of In Vitro Fertilization and Embryo Transfer* 5 (1988): 245-48.

- Leon, I.G. "The Invisible Loss: The Impact of Perinatal Death on Siblings." *Journal of Psychosomatic Obstetrics and Gynecology* 5 (1986): 1-14.
- Lepofsky, M.D. "Equality and Disabled Persons." In *Justice Beyond Orwell*, ed. R.S. Abella and M.L. Rothman. Montreal: Éditions Yvon Blais, 1985.
- Lepofsky, M.D., and J.E. Bickenbach. "Equality Rights and the Physically Handicapped." In *Equality Rights and the Canadian Charter of Rights and Freedoms*, ed. A. Bayefsky and M. Eberts. Toronto: Carswell, 1985.
- "Measures to Assist the Most Vulnerable Groups." In *United Nations Action in the Field of Human Rights*. New York: United Nations, 1983.
- Mellown, M.R. "An Incomplete Picture: The Debate About Surrogate Motherhood." *Harvard Women's Law Journal* 8 (1985): 231-46.
- Millen, L., and S. Roll. "Solomon's Mothers: A Special Case of Pathological Bereavement." *American Journal of Orthopsychiatry* 55 (1985): 411-18.
- Mnookin, R.H. "Child Custody Adjudication: Judicial Functions in the Face of Indeterminacy." *Law and Contemporary Problems* 39 (1975): 226.
- Morgan, D. "Human Fertilisation and Embryology Bill: The Status Provisions." *Journal of Social Welfare Law* 2 (1990): 120-22.
- . "Surrogacy: An Introductory Essay." In *Birthrights: Law and Ethics at the Beginnings of Life*, ed. R. Lee and D. Morgan. London: Routledge, 1989.
- Morgan, D., and R.G. Lee. *Blackstone's Guide to the Human Fertilisation and Embryology Act 1990: Abortion and Embryo Research: The New Law*. London: Blackstone Press, 1991.
- Murray, P.G. "Section One of the Canadian Charter of Rights and Freedoms: An Examination of Two Levels of Interpretation." *Ottawa Law Review* 21 (1989): 631-77.
- Nabors, T. "Clinical Treatment of the Infertile Couple." In *Technological Powers and the Person: Nuclear Energy and Reproductive Technologies*. St. Louis: Pope John XXIII Medical-Moral Research Center, 1983.
- Navot, D., and N. Laufer. "Assisted Reproductive Technology: A Clinical Appraisal." *Journal of Reproductive Medicine* 34 (1989): 3-9.
- New York State. Senate Judiciary Committee. *Surrogate Parenting in New York: A Proposal for Legislative Reform*. Albany: The Senate of the State of New York, 1987 (Chair: John R. Dunne).
- New York State Task Force on Life and the Law. *Surrogate Parenting: Analysis and Recommendations for Public Policy*. Albany: 1988.
- Nickman, S. "Losses in Adoption." *Psychoanalytic Study of the Child* 40 (1985): 365.
- O'Brien, M. *The Politics of Reproduction*. London: Routledge and Kegan Paul, 1981.
- O'Brien, S. "The Itinerant Embryo and the Neo-Nativity Scene: Bifurcating Biological Maternity." *Utah Law Review* (1987): 1-33.
- Ontario Law Reform Commission. *Report on Human Artificial Reproduction and Related Matters*. Toronto: Ministry of the Attorney General, 1985.

- Ontario. Provincial Secretariat for Social Development. *The Family as a Focus for Social Policy*. Toronto: 1979.
- Overvold, A.Z. *Surrogate Parenting*. New York: Pharos Books, 1989.
- Parker, P.J. "Motivation of Surrogate Mothers: Initial Findings." *American Journal of Psychiatry* 140 (1983): 117-18.
- . "The Psychology of the Surrogate Mother: A Newly Updated Report of a Longitudinal Pilot Study." Paper presented at the American Orthopsychiatric Association General Meeting, Toronto, 9 April 1984.
- . "Surrogate Motherhood, Psychiatric Screening and Informed Consent, Baby Selling and Public Policy." *Bulletin of the American Academy of Psychiatry and the Law* 12 (1984): 21-39.
- Paulson, R.J., M.V. Sauer, and R.A. Lobo. "In Vitro Fertilization in Unstimulated Cycles: A New Application." *Fertility and Sterility* 51 (1989): 1059-60.
- Poff, D. "Content, Intent and Consequences: Life Production and Reproductive Technology." *Atlantis* 13 (1988): 111-15.
- Pollitt, K. "When Is a Mother Not a Mother?" *The Nation* (31 December 1990): 826 *et seq.*
- Posner, R.A. "The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood." *Journal of Contemporary Health Law and Policy* 5 (1989): 21-31.
- Raymond, J.G. "The International Traffic in Women: Women Used in Systems of Surrogacy and Reproduction." *Reproductive and Genetic Engineering* 2 (1989): 51-57.
- . "Reproductive Gifts and Gift Giving: The Altruistic Woman." *Hastings Center Report* 20 (November-December 1990): 7-11.
- "Relinquishing Mothers." *Medical Journal of Australia* 144 (1986): 553.
- Robertson, J.A. "Decisional Authority over Embryos and Control of IVF Technology." *Jurimetrics* 28 (1988): 285-304.
- . "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction." *Southern California Law Review* 59 (1986): 939-1041.
- . "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth." *Virginia Law Review* 69 (1983): 405-64.
- . "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction." *Law, Medicine & Health Care* 16 (1-2)(1988): 18-26.
- . "Procreative Liberty, Embryos and Collaborative Reproduction." Paper presented at the U.K. National Committee of Comparative Law 1987 Colloquium, "Legal Regulation of Reproductive Medicine," Girton College, Cambridge, England, 15-17 September 1987.
- . "Procreative Liberty, Embryos, and Collaborative Reproduction: A Legal Perspective." *Women and Health* 13 (1987): 179-94.
- . "Surrogate Mothers: Not So Novel After All." *Hastings Center Report* 13 (October 1983): 28-34.
- . "Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation." *Case Western Reserve Law Review* 39 (1988-89): 1-38.

- Rothenberg, K.H. "Gestational Surrogacy and the Health Care Provider: Put Part of the 'IVF Genie' Back into the Bottle." *Law, Medicine & Health Care* 18 (1990): 345-52.
- Rothman, B.K. *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*. New York: Viking Penguin, 1986.
- Rule, A. *Small Sacrifices*. New York: Signet, 1988.
- Rushevsky, C. "Legal Recognition of Surrogate Gestation." *Women's Rights Law Reporter* 7 (1982): 107-42.
- Ryder, B. "Equality Rights and Sexual Orientation: Confronting Heterosexual Family Privilege." *Canadian Journal of Family Law* 9 (1990-91): 39-97.
- Rynearson, E.K. "Relinquishment and Its Maternal Complications: A Preliminary Study." *American Journal of Psychiatry* 139 (1982): 338-40.
- Sandberg, E.C. "Only an Attitude Away: The Potential of Reproductive Surrogacy." *American Journal of Obstetrics and Gynecology* 160 (1989): 144-46.
- Savory, L. "At What Price, Freedom? — The Surrogate Motherhood Debate." *Waterlily* 2 (Fall 1990): 20.
- Schneider, C.E. "Surrogate Motherhood from the Perspective of Family Law." *Harvard Journal of Law & Public Policy* 13 (Winter 1990): 124-31.
- Schuck, P.H. "The Social Utility of Surrogacy." *Harvard Journal of Law & Public Policy* 13 (1990): 132-38.
- Scutt, J.A. "Book Reviews." *Issues in Reproductive and Genetic Engineering* 3 (190): 73-81.
- Seibel, M., and W.L. Graves. "The Psychological Implications of Spontaneous Abortion." *Journal of Reproductive Medicine* 25 (1980): 161-65.
- Sheean, L.A., et al. "In Vitro Fertilization (IVF) — Surrogacy: Application of IVF to Women Without Functional Uteri." *Journal of In Vitro Fertilization and Embryo Transfer* 6 (1989): 134-37.
- Sieghart, P. *The International Law of Human Rights*. Oxford: Clarendon Press, 1983.
- Sloman, S. "Surrogacy Arrangements Act, 1985." *New Law Journal* (4 October 1985): 978.
- Smart, C. "Power and the Politics of Child Custody." In *Child Custody and the Politics of Gender*, ed. C. Smart and S. Sevenhuijsen. London: Routledge, 1989.
- Snyder, D. "Stand-in Mother." *Health* 17 (April 1985): 65-67.
- Sokoloff, B.Z. "Alternative Methods of Reproduction: Effects on the Child." *Clinical Pediatrics* 26 (January 1987): 11-16.
- Steadman, J.H., and G.T. McCloskey. "The Prospect of Surrogate Mothering: Clinical Concerns." *Canadian Journal of Psychiatry* 32 (1987): 545-50.
- Steptoe, P. Letter. *British Medical Journal* (27 June 1987): 1688-89.
- Stevens, K., with E. Daily. *Surrogate Mother: One Woman's Story*. London: Century, 1985.

- Stirtzinger, R., and G.E. Robinson. "The Psychological Effects of Spontaneous Abortion." *Canadian Medical Association Journal* 146 (1989): 799-800.
- Stuart, A. "Is It Worth It? I Just Don't Know." In *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine*, ed. R.P. Klein. London: Pandora Press, 1989.
- Stuart, D. "Will Section 1 Now Save Any Charter Violation? The Chaulk Effectiveness Test Is Improper." *C.R.* (4th) 2 (1991): 107-17.
- Stumpf, A.E. "Redefining Mother: A Legal Matrix for New Reproductive Technologies." *Yale Law Journal* 96 (1986): 187-208.
- Sullivan, L. "Surrogacy: The Case for a Conventional Approach." *Medicine and Law* 10 (1991): 401-15.
- "Surrogate Parenting Center Sets Stringent Selection Criteria: RNs Ideal Candidates." *Nurses Week* (5 February 1990).
- Tribe, L.H. *American Constitutional Law*. 2d ed. Mineola: Foundation Press, 1988.
- Trounson, A.O., et al. "Pregnancies in Humans by Fertilization *In Vitro* and Embryo Transfer in the Controlled Ovulatory Cycle." *Science* 212 (1981): 681-82.
- United Kingdom. Department of Health and Social Security. *Report of the Committee of Inquiry into Human Fertilisation and Embryology*. Cmnd 9314. London: HMSO, 1984 (Chair: Dame Mary Warnock).
- "United Nations Convention on the Rights of the Child." In *Children's Rights in America: U.N. Convention on the Rights of the Child Compared with United States Law*, ed. C.P. Cohen and H.A. Davidson. Chicago: American Bar Association Center on Children and the Law, 1990.
- United Nations General Assembly. "Declaration of the Rights of the Child." In *Basic Documents on Human Rights*, ed. I. Brownlie. Oxford: Clarendon Press, 1971.
- . "International Covenant on Civil and Political Rights." In *Basic Documents on Human Rights*, ed. I. Brownlie. Oxford: Clarendon Press, 1971.
- . "International Covenant on Economic, Social and Cultural Rights." In *Basic Documents on Human Rights*, ed. I. Brownlie. Oxford: Clarendon Press, 1971.
- . "Optional Protocol to the International Covenant on Civil and Political Rights." In *Basic Documents on Human Rights*, ed. I. Brownlie. Oxford: Clarendon Press, 1971.
- . "Universal Declaration of Human Rights." In *Basic Documents on Human Rights*, ed. I. Brownlie. Oxford: Clarendon Press, 1971.
- United States. Congress. House. Committee on Energy and Commerce. Subcommittee on Transportation, Tourism and Hazardous Materials. *Hearing on a Bill to Prohibit Certain Arrangements Commonly Called Surrogate Motherhood and for Other Purposes*. 100th Cong., 15 October 1987. Serial No. 100-143. Washington, DC: U.S. Government Printing Office, 1988.
- United States. Congress. Office of Technology Assessment. *Infertility: Medical and Social Choices*. Washington, DC: U.S. Government Printing Office, 1988.
- Utian, W.H., et al. Letter to the Editor. *New England Journal of Medicine* 313 (1985): 1351.

- . "Preliminary Experience with In Vitro Fertilization — Surrogate Gestational Pregnancy." *Fertility and Sterility* 52 (1989): 633-38.
- Waldron, J. "Theoretical Foundations of Liberalism." *Philosophical Quarterly* 37 (1987): 127-50.
- Walker, R. "The Market in Babies." *Canadian Lawyer* 11 (February 1987): 20-22.
- Walters, W.A.W., and P. Singer. *Test-Tube Babies: A Guide to Moral Questions, Present Techniques and Future Possibilities*. Melbourne: Oxford University Press, 1982.
- Wardle, L.D., et al. "Creating Family Relations." In *Contemporary Family Law*. Vol. 1. Deerfield: Callaghan and Company, 1989.
- Weil, R. "Interview: Alan O. Trounson." *Omni* (December 1985): 83-84.
- Whitehead, M.B. *A Mother's Story*. New York: St. Martin's Press, 1989.
- Wilson, J., and M. Tomlinson. *Children and the Law*. 2d ed. Toronto: Butterworths, 1986.
- Winkler, R., and M. van Keppel. *Relinquishing Mothers in Adoption: Their Long-Term Adjustment*. Melbourne: Institute of Family Studies, 1984.
- Winkler, U. "New U.S. Know-How in Frankfurt — A 'Surrogate Mother' Agency." *Reproductive and Genetic Engineering* 1 (1988): 205-207.
- Wood, E.C., and P. Singer. "Whither Surrogacy?" *Medical Journal of Australia* 149 (1988): 426.
- Wright, M. "Surrogacy and Adoption: Problems and Possibilities." *Family Law* 16 (1986): 109-13.
- Yovich, J.L., and T.D. Hoffman. "IVF Surrogacy and Absent Uterus Syndromes." *Lancet* (6 August 1988): 331-32.
- Zeanah, C.H. "Adaptation Following Perinatal Loss: A Critical Review." *Journal of the American Academy of Child and Adolescent Psychiatry* 28 (1989): 467-80.

Cases

A v. C., [1985] F.L.R. 445.

Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143, (1989) 56 D.L.R. (4th) 1.

Anna J v. Mark C, 286 Cal. Rptr. 369 (Cal. App. 4 Dist. 1991).

Borowski v. Canada (A.G.), [1989] 1 S.C.R. 342.

Bowers v. Hardwick, 478 U.S. 186 (1986).

Carey v. Population Services International, 431 U.S. 678 (1977).

Catholic Children's Aid Society of Metropolitan Toronto v. S.T. (1989), 60 D.L.R. (4th) 397 (Ont. C.A.).

Children's Aid Society of Halifax v. G.H. (1989), 85 N.S.R. (2d) 286 (Fam. Ct.).

Children's Aid Society of Hamilton-Wentworth v. K. (L.) (1989), 70 O.R. (2d) 466 (U.F. C.).

Chisholm v. Chisholm (1908), 40 S.C.R. 115.

- Ciarlariello v. Schacter* (1991), 5 C.C.L.T. (2d) 221 (Ont. C.A.).
City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983).
Duke v. R. (1972), 28 D.L.R. (3d) 129.
Eisenstadt v. Baird, 405 U.S. 438 (1972).
Fleming v. Reid (1991), 4 O.R. (3d) 74 (Ont. C.A.).
Ford v. Quebec (Attorney General), [1988] 2 S.C.R. 712, (1988) 54 D.L.R. (4th) 577.
Fox v. Dalzell (1982), 28 R.F.L. (2d) 174 (Ont. Prov. Ct. Fam. Div.).
G. (F.) v. G. (F.) (1991), 32 R.F.L. (3d) 252.
Griswold v. Connecticut, 381 U.S. 479 (1965).
H. v. H. (1979), 9 R.F.L. (2d) 216 (Ont. Supreme Ct., Fam. Div.).
Humphrys v. Polak and Wife, [1901] 2 K.B. 385 (C.A.).
In re Adoption of Reams, 557 N.E. 2d 159 (Ohio App. 1989).
In re Baby Girl, 9 F.L.R. 2348 (Ky. Cir. Ct., 1983).
In re R.K.S., 10 F.L.R. 1383 (D.C. Super. Ct. Fam. Div., 1984).
In the Matter of Adoption of Baby Girl L.J., 505 N.Y.S. 2d 813 (Sur. 1986).
In the Matter of Adoption of Paul, 550 N.Y.S. 2d 815 (Fam. Ct. 1990).
In the Matter of Baby "M." 525 A. 2d 1128 (N.J. Super. Ch. 1987); 537 A. 2d 1227 (N.J. Sup. Ct. 1988).
Irwin Toy Ltd. v. Quebec (A.G.), [1989] 1 S.C.R. 927, (1989) 58 D.L.R. (4th) 577.
Jane Doe et al. v. A.G. Michigan, Docket No. 88-819032-C2, Wayne County Circuit Court, 9 September 1988.
K.K. v. G.L. and B.J.L. (King v. Low) (1985), 44 R.F.L. (2d) 113 (S.C.C.).
Lord St. John v. Lady St. John (1805), 11 Ves. Jun. 525, 32 E.R. 1192 (Ch.).
Loving v. Virginia, 388 U.S. 1 (1967).
Lyons v. Blenkin (1820), Jacob 246, 37 E.R. 842 (Ch.).
M. v. W. and R. (1985), 45 R.F.L. (2d) 337 (B.C.S.C.J.).
Meyer v. Nebraska, 262 U.S. 390 (1923).
Mouritsen v. Shepley (1979), 11 R.F.L. (2d) 285 (Ont. Co. Ct.).
Nancy B. v. Hôtel-Dieu de Québec (1992), 86 D.L.R. (4th) 385 (Que. Superior Ct.).
Paton v. British Pregnancy Advisory Service Trustees, [1979] 1 Q.B. 276.
Pierce v. Society of the Sisters, 268 U.S. 510 (1924).
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).
Quilloin v. Walcott, 434 U.S. 246 (1978).
R. v. Barnardo (1889), 23 Q.B.D. 305 (C.A.).
R. v. Beare, [1988] 2 S.C.R. 387.
R. v. Chaulk (1990), 2 C.R. (4th) 1.
R. v. Edwards Books and Art Ltd., [1986] 2 S.C.R. 713, (1986) 35 D.L.R. (4th) 1.

- R. v. Jones*, [1986] 2 S.C.R. 284, [1986] 6 W.W.R. 577.
- R. v. Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385.
- R. v. Oakes*, [1986] 1 S.C.R. 103, (1986) 26 D.L.R. (4th) 200.
- R. v. Therens*, [1985] 1 S.C.R., 613, (1985) 18 D.L.R. (4th) 655.
- R. v. Turpin*, [1989] 1 S.C.R. 1296, (1989) 48 C.C.C. (3d) 8.
- Re an Adoption Application (Surrogacy)*, [1987] 2 All E.R. 826 (U.K. Fam. Div.).
- Re Bhindi and British Columbia Projectionists* (1986), 29 D.L.R. (4th) 47 (B.C.C.A.); leave to appeal refused [1986] 2 S.C.R. v.
- Re C (A Minor) (Wardship: Surrogacy)*, [1985] F.L.R. 846 (U.K. Fam. Div.).
- Re Cartilage and Cartilage* (1973), 3 O.R. 801.
- Re C.P.L.* (1988), 70 Nfld. & P.E.I.R. 287 (Nfld. U.F.C.).
- Re P (Mtnors) (Wardship: Surrogacy)*, [1987] 2 F.L.R. 421.
- Re Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177, (1985) 17 D.L.R. (4th) 422.
- Re T and Catholic Children's Aid Society of Metropolitan Toronto* (1984), 46 O.R. (2d) 347 (Prov. Ct.).
- Reference Re Section 94(2) of the Motor Vehicle Act, R.S.B.C. 1979, c. 288*, [1985] 2 S.C.R. 486, [1986] 1 W.W.R. 481 (S.C.C.).
- Reference re ss. 193 and 195.1(1)(c) of the Criminal Code* (1990), 56 C.C.C. (3d) 65 (S.C.C.).
- Reid (Gray) v. Gray* (1976), 29 R.F.L. 63 (B.C.S.C.).
- Retail, Wholesale and Department Store Union, Local 580 v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573.
- Richardson v. Richardson* (1987), 7 R.F.L. (3d) 304.
- Roberts v. Hall* (1882), 1 O.R. 388 (Ch.).
- Rocket v. Royal College of Dental Surgeons of Ontario*, [1990] 2 S.C.R. 232, (1990) 71 D.L.R. (4th) 68.
- Roe v. Wade*, 410 U.S. 113 (1973).
- Sherwyn & Handel v. California State Department of Social Services*, 218 Cal. Rptr. 778 (Cal. App. 2 Dist. 1985).
- Skinner v. Oklahoma*, 316 U.S. 535 (1942).
- Stanley v. Illinois*, 405 U.S. 645 (1972).
- Surrogate Parenting Associates v. Commonwealth of Kentucky ex. rel. Armstrong*, 704 S.W. 2d 209 (1986).
- Swift v. Swift* (1865), 34 Beav. 266, 55 E.R. 637 (Rolls).
- Syrkowski v. Appleyard*, 333 N.W. 2d 90 (Mich. App., 1983) and 362 N.W. 2d 211 (Mich. 1985).
- Thornborough v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

Thrane v. Noyes, 7 F.L.R. 2351 (1981).

Tremblay v. Dalgle, [1989] 2 S.C.R. 530, (1989), 62 D.L.R. (4th) 634.

Vansittart v. Vansittart (1858), 2 De G. & J. 249, 44 E.R. 984 (C.A. Ch.).

Yates v. Keane, 14 F.L.R. 1160 (1987).

Zablocki v. Redhail, 434 U.S. 374 (1978).

Surrogate Parenting: Bibliography

Compiled by Jennifer Kitts



Executive Summary

This bibliography was compiled by the Commission early in its mandate to give an overview of the literature in the area of surrogate parenting. It is intended to provide a concise catalogue of the available literature in this specific area. While not exhaustive, the material listed below comprises a listing of books, articles, and theses examining the medical, social, ethical, and legal aspects of surrogate parenting as of 1990. The sources cited are, for the most part, available in general reference or university libraries.

Bibliography

- Achilles, R. "Artificial Reproduction: Hope Chest or Pandora's Box?" In *Changing Patterns: Women in Canada*, ed. S. Burt, L. Code, and L. Dorney. Toronto: McClelland and Stewart, 1988.
- . "Desperately Seeking Babies: New Technologies of Hope and Despair." In *Delivering Motherhood: Maternal Ideologies and Practices in the 19th*

and 20th Centuries, ed. K. Arnup, A. Lévesque, and R.R. Pierson. London: Routledge and Kegan Paul, 1990.

Actes du Colloque Génétique, Procréation et Droit. Paris: Actes Sud, 1985.

Agich, G.J. "Genetic Justice." *University of Western Ontario Law Review* 24 (1)(1986): 39-50.

Alberta Advisory Council on Women's Issues. "Discussion Paper on New Reproductive Technologies — Medical, Legal and Ethical Implications." Alberta, 1988.

American Bar Association Section of Family Law Adoption Committee and Ad Hoc Surrogacy Committee. "Draft ABA Model Surrogacy Act." *Family Law Quarterly* 22 (1988): 123-43.

American Fertility Society. Ethics Committee. "Ethical Considerations of the New Reproductive Technologies." *Fertility and Sterility* 53 (Suppl. 2)(1990).

—. "Surrogate Gestational Mothers: Women Who Gestate a Genetically Unrelated Embryo." *Fertility and Sterility* 46 (Suppl.)(1986): 58S-61S.

—. "Surrogate Mothers." *Fertility and Sterility* 46 (Suppl.)(1986): 62S-68S.

Andrews, L.B. "The Aftermath of Baby M: Proposed State Laws on Surrogate Motherhood." *Hastings Center Report* 17 (October-November 1987): 31-40.

—. *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies*. New York: Harper and Row, 1989.

—. "Legal and Ethical Aspects of New Reproductive Technologies." *Clinical Obstetrics and Gynaecology* 29 (1986): 190-204.

—. "Legal Aspects of Assisted Reproduction." *Annals of the New York Academy of Sciences* 541 (1988): 668-78.

—. "My Body, My Property." *Hastings Center Report* 16 (October 1986): 28-38.

—. *New Conceptions: A Consumer's Guide to the Newest Infertility Treatments, Including In Vitro Fertilization, Artificial Insemination and Surrogate Motherhood*. New York: St. Martin's, 1984.

—. "Removing the Stigma of Surrogate Motherhood." *Family Advocate* 4 (Fall 1981): 20-25, 44.

—. "The Stork Market: The Law of the New Reproduction Technologies." *ABA Journal* 70 (August 1984): 50-56.

—. "Surrogate Motherhood: The Challenge for Feminists." *Law, Medicine and Health Care* 18 (1-2)(1988): 72-80.

Andrews, L.B. (and commentary by H.O. Tiefel). "When the Baby's Mother Is Also Grandma and Sister." *Hastings Center Report* 15 (October 1985): 29-31.

- Annas, G.J. "The Baby Broker Boom." *Hastings Center Report* 16 (June 1986): 30-31.
- . "Baby M: Babies (and Justice) for Sale." *Hastings Center Report* 17 (June 1987): 13-15.
- . "Contracts to Bear a Child: Compassion or Commercialism?" *Hastings Center Report* 11 (April 1981): 23-24.
- . "Crazy Making: Embryos and Gestational Mothers." *Hastings Center Report* 21 (January-February 1991): 35-38.
- . "Death Without Dignity for Commercial Surrogacy: The Case of Baby M." *Hastings Center Report* 18 (April-May 1988): 21-24.
- . "Fairy Tales Surrogate Mothers Tell." *Law, Medicine and Health Care* 16 (1-2)(1988): 27-33.
- . "Fathers Anonymous: Beyond the Best Interests of the Sperm Donor." In *Genetics and the Law II*, ed. A. Milunsky and G.J. Annas. New York: Plenum Press, 1980.
- . "The Impact of Medical Technology on the Pregnant Woman's Right to Privacy." *American Journal of Law and Medicine* 13 (1987): 213-32.
- . "Making Babies Without Sex: The Law and the Profits." *American Journal of Public Health* 74 (1984): 1415-17.
- . "Pregnant Women as Fetal Containers." *Hastings Center Report* 16 (December 1986): 13-14.
- . "Redefining Parenthood and Protecting Embryos: Why We Need New Laws." *Hastings Center Report* 14 (October 1984): 50-52.
- . "Surrogate Embryo Transfer: The Perils of Patenting." *Hastings Center Report* 14 (June 1984): 25-26.
- Annas G.J., and S. Elias. "In Vitro Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family." *Family Law Quarterly* 17 (1983): 199-223.
- Arditti, R. "Reducing Women to Matter." [Book Review of Gena Corea's *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* (New York: Harper and Row, 1985).] *Women's Studies International Forum* 8 (1985): 577-82.
- . "A Summary of Some Recent Developments on Surrogacy in the United States." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 51-64.
- . "The Surrogacy Business." *Social Policy* 18 (Fall 1987): 42-46.
- . "Surrogacy in Argentina." *Issues in Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 3 (1990): 35-43.
- Arditti, R., R.D. Klein, and S. Minden, eds. *Test-Tube Women: What Future for Motherhood?* London: Pandora Press, 1984.

- Armstrong, S.M. "Womb and Board: Medical Advances in Reproduction — At What Costs?" *Medical Trial Technique Quarterly* 33 (1987): 465-77.
- Atherton, R.F. "Artificially Conceived Children and Inheritance in New South Wales." *Australian Law Journal* 60 (July 1986): 374-86.
- Austin, C.R. "The Surrogate Triplets of Perth, Western Australia." *Human Reproduction* 4 (April 1989): 346.
- Australia. Family Law Council. *Creating Children: A Uniform Approach to the Law and Practice of Reproductive Technology in Australia*. Canberra, 1985.
- Australia. Victoria. Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization. *Report on the Disposition of Embryos Produced by In Vitro Fertilization*. Melbourne, 1984.
- "The Baby M Case and Surrogate Motherhood." *Australian Law Journal* 61 (1987): 322-24.
- Barnes, R.L. "Delusion by Analysis: The Surrogate Mother Problem." *South Dakota Law Review* 34 (1989): 1-19.
- Barnett, D.L. "In Vitro Fertilization: Third Party Motherhood and the Changing Definition of Legal Parent." *Pacific Law Journal* 17 (1985): 231-59.
- Barreau du Québec. Comité sur les nouvelles technologies de reproduction humaine. *Les enjeux éthiques et juridiques des nouvelles technologies de reproduction*. Montreal: Éditions Yvon Blais, 1988.
- Barry, K. *Female Sexual Slavery*. Englewood Cliffs: Prentice-Hall, 1979.
- Baruch, E.H., and A.F. D'Adamo. "Resetting the Biological Clock: Women and the New Reproductive Technologies." *Dissent* 32 (Summer 1985): 273-76.
- Bates, P. "Foetal and Neonatal Life, Death and the Law." *Legal Service Bulletin* 9 (1) (1984) and *New Doctor* 31 (February-March 1984): 40-43. (Joint issue)
- Baudouin, J.-L. "Bref aperçu de la situation au Canada." In *Actes du Colloque Génétique, Procréation et Droit*. Paris: Actes Sud, 1985.
- Baycroft, J., ed. *Whose Child Is This? Ethical, Legal, and Theological Dangers of "Surrogate Motherhood."* Toronto: Anglican Book Centre, 1990.
- Bayles, M.D. *Reproductive Ethics*. Englewood Cliffs: Prentice-Hall, 1984.
- Beauchamp, T.L., and J.F. Childress. *Principles of Biomedical Ethics*. 3d ed. New York: Oxford University Press, 1989.
- Begin, P. "New Reproductive Technologies." Backgrounder. Ottawa: Library of Parliament, 1989.

- Bettenhausen, E. "Hagar Revisited: Surrogacy, Alienation and Motherhood." *Christianity and Crisis* 47 (4 May 1987): 157-59.
- Bezanson, R.P. "Solomon Would Weep: A Comment on *In the Matter of Baby M* and the Limits of Judicial Authority." *Law, Medicine and Health Care* 16 (1-2)(1988): 126-30.
- Bhimji, S. "Womb for Rent: Ethical Aspects of Surrogate Motherhood." *Canadian Medical Association Journal* 137 (1987): 1132-35.
- "Biomedical Ethics: A Multinational View." *Hastings Center Report* 17 (Suppl.)(June 1987): 1-36.
- Bird, K. "Surrogate Motherhood: Hers? Yours? Ours?" *California Lawyer* 2 (February 1982): 20-25.
- Bishop, K. "The Brave New World of Baby Making." *California Lawyer* 6 (August 1986): 36-41.
- Bissett-Johnson, A., and C.J. Cavett. "The Legacy of Baby M: Drafting and Contractual Problems." *Canadian Family Law Quarterly* 2 (1987): 299-344.
- Bitner, L.A. "Womb for Rent: A Call for Pennsylvania Legislation Legalizing and Regulating Surrogate Parenting Agreements." *Dickinson Law Review* 90 (1985): 227-59.
- Black, R.C. "Legal Problems of Surrogate Motherhood." *New England Law Review* 16 (1981): 373-95.
- Black, S.G. "Baby M: Motherhood and Money." *Gonzaga Law Review* 24 (1988/89): 515-37.
- Blake, J. "Coercive Pronatalism and American Population Policy." In *Pronatalism: The Myth of Mom & Apple Pie*, ed. E. Peck and J. Senderowitz. New York: Thomas Y. Crowell, 1974.
- Blakely, M.K. "Surrogate Mothers: For Whom Are They Working?" *Ms.* 11 (March 1983): 18, 20.
- Boné, E. "From Biotechnology to Bioethics: The Shock of the Future." *Pro Mundi Vita* 101 (1985): 1-42.
- Boston Women's Health Book Collective. *The New Our Bodies, Ourselves*. Rev. ed. New York: Simon and Schuster, 1984.
- Bowal, P. "Surrogate Procreation: A Motherhood Issue in Legal Obscurity." *Queen's Law Journal* 9 (1983): 5-34.
- Brahams, D. "Abortion and Assisted Parenthood in USA." *Lancet* (26 January 1991): 228-29.
- . "The Hasty British Ban on Commercial Surrogacy." *Hastings Center Report* 17 (February 1987): 16-19.
- . "Surrogacy, Adoption, and Custody." *Lancet* (4 April 1987): 817.

- Brodrribb, S. "Delivering Babies: Contracts and Contradictions." In *The Future of Human Reproduction*, ed. C. Overall. Toronto: Women's Press, 1989.
- . "Off the Pedestal and onto the Block? Motherhood, Reproductive Technologies, and the Canadian State." *Canadian Journal of Women and the Law* 1 (1986): 407-23.
 - . "Reproductive Technologies, Masculine Dominance and the Canadian State." *Occasional Papers in Social Policy Analysis*. Toronto: Ontario Institute for Studies in Education, 1984.
- Bromley, P. "Aided Conception: The Alternative to Adoption." In *Adoption: Essays in Social Policy, Law and Sociology*, ed. P. Bean. London: Tavistock, 1984.
- Brophy, K.M. "A Surrogate Mother Contract to Bear a Child." *Journal of Family Law* 20 (1981-82): 263-91.
- Brown, H., et al. "Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth." *Vanderbilt Law Review* 39 (1986): 597-850.
- Budde, J.K. "Surrogate Parenting: Future Legislation to Eliminate Present Inconsistencies." *Duquesne Law Review* 26 (1988): 633-56.
- Burfoot, A. "The Normalisation of a New Reproductive Technology." In *The New Reproductive Technologies*, ed. M. McNeil, I. Varcoe, and S. Yearley. London: Macmillan, 1990.
- Cahill, L.S. "The Ethics of Surrogate Motherhood: Biology, Freedom and Moral Obligation." *Law, Medicine and Health Care* 16 (1-2)(1988): 65-71.
- . "The 'Seamless Garment': Life in Its Beginnings." *Theological Studies* 46 (March 1985): 64-80.
- Canadian Advisory Council on the Status of Women. *Prostitution in Canada*. Ottawa: CACSW, 1984.
- Cappuccio, M.S. "Surrogate Motherhood in Ohio: A Dangerous Game of Baby Roulette." *Capital University Law Review* 15 (Fall 1985): 93-110.
- Capron, A.M. "Alternative Birth Technologies: Legal Challenges." *U.C. Davis Law Review* 20 (1987): 679-704.
- Capron, A.M., and M.J. Radin. "Choosing Family Law over Contract Law as a Paradigm for Surrogate Motherhood." *Law, Medicine and Health Care* 16 (1-2)(1988): 34-43.
- Cass, R.A. "Coping with Life, Law, and Markets: A Comment on Posner and the Law-and-Economics Debate." *Boston University Law Review* 67 (1987): 73-97.
- Cassidy, H.J. "What Is in Baby M's 'Best Interest' and What Standard Should Apply?" *National Law Journal* 10 (26 October 1987): 19-20.

- Chalmers, D.R. "No Primrose Path: Surrogacy and the Role of the Criminal Law." *Medicine and Law* 7 (1989): 595-606.
- Charo, R.A. "Legislative Approaches to Surrogate Motherhood." *Law, Medicine and Health Care* 16 (1-2)(1988): 96-112.
- . "Problems in Commercialized Surrogate Mothering." In *Embryos, Ethics, and Women's Rights: Exploring the New Reproductive Technologies*, ed. E.H. Baruch, A.F. D'Adamo, Jr., and J. Seager. New York: Harrington Park Press, 1988.
- Chell, B. "But Murderers Can Have All the Children They Want: Surrogacy and Public Policy." *Theoretical Medicine* 9 (February 1988): 3-21.
- Chesler, P.A. *Sacred Bond: The Legacy of Baby M*. Toronto: Random House of Canada, 1989.
- Choquette, M. *Nouvelles technologies de la reproduction: étude des principales législations et recommandations*. Quebec: Conseil du statut de la femme, 1986.
- Clark, N.L. "New Wine in Old Skins: Using Paternity-Suit Settlements to Facilitate Surrogate Motherhood." *Journal of Family Law* 25 (1986-87): 483-527.
- Cohen, B. "Surrogate Mothers: Whose Baby Is It?" *American Journal of Law and Medicine* 10 (1984): 243-85.
- Cohen, B., and T.L. Friend. "Legal and Ethical Implications of Surrogate Mother Contracts." *Clinics in Perinatology* 14 (1987): 281-92.
- Coleman, P. "Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions." *Tennessee Law Review* 50 (1982): 71-119.
- Congregation for the Doctrine of the Faith. *Instruction on Respect for Human Life in Its Origin and on the Dignity of Human Reproduction*. Vatican City, 1987.
- Cook, R.J., and B.M. Dickens. *Issues in Reproductive Health Law in the Commonwealth*. London: Commonwealth Secretariat, 1986.
- Corea, G. "How the New Reproductive Technologies Could Be Used to Apply the Brothel Model of Social Control over Women." *Women's Studies International Forum* 8 (1985): 299-305.
- Corea, G. *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper and Row, 1985.
- Corea, G., and C. de Wit. "Current Developments and Issues: A Summary." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 87-102, 183-203, 287-307.
- Corea, G., et al., eds. *Man-Made Women: How New Reproductive Technologies Affect Women*. Indiana: Indiana University Press, 1987.

- Crowe, C. "1Women Want It': *In-Vitro Fertilization and Women's Motivations for Participation.*" *Women's Studies International Forum* 8 (1985): 547-52.
- Cunningham, K.J. "Surrogate Mother Contracts: Analysis of a Remedial Quagmire." *Emory Law Journal* 37 (1988): 721-53.
- Cusine, D. "Legal Issues in Human Reproduction." In *Legal Issues in Human Reproduction*, ed. S. McLean. Aldershot: Gower, 1989.
- . "'Womb-Leasing': Some Legal Implications." *New Law Journal* 128 (1978): 824-25.
- Davies, I. "Contracts to Bear Children." *Journal of Medical Ethics* 11 (1985): 61-65.
- De Wachter, M.A.M., and G.M.W.R. De Wert. "Reproductive Technology: In The Netherlands, Tolerance and Debate." *Hastings Center Report* 17 (Suppl.)(June 1987): 15-16.
- Diamond, I. "Medical Science and the Transformation of Motherhood: The Promise of Reproductive Technologies." In *Women, Power and Policy: Toward the Year 2000*. 2d ed., ed. E. Boneparth and E. Stopper. New York: Pergamon Press, 1988.
- Dickens, B.M. "Artificial Reproduction and Child Custody." *Canadian Bar Review* 66 (1987): 49-75.
- . "Conference de Bernard M. Dickens." In *Conseil du statut de la femme, Sortir la maternité du laboratoire*, Actes du forum international sur les nouvelles technologies de la reproduction organisé par le Conseil du statut de la femme, Montreal, 1987. Quebec, 1988.
- . "Reproduction Law and Medical Consent." *University of Toronto Law Journal* 35 (1985): 255-86.
- . "The Role of the Family in Surrogate Medical Consent." *Health Law in Canada* 1 (Autumn 1980): 49-52.
- . "Surrogate Motherhood, Legal and Legislative Issues." In *Genetics and the Law III*, ed. A. Milunsky and G.J. Annas. New York: Plenum Press, 1985.
- Dixon, K.M., et al. "A Case of Surrogate Pregnancy." *Journal of Family Practice* 30 (1990): 19-26.
- Dodd, B.J. "The Surrogate Mother Contract in Indiana." *Indiana Law Review* 15 (1982): 807-30.
- Donchin, A. "Reproductive Technology and Moral Responsibility: Redefining Parenthood." Paper presented at the Second International Congress on Women's Health Issues, Halifax, 6-8 November 1986.
- Downie, S. *Babymaking: The Technology and Ethics*. London: Bodley Head, 1988.

- Drori, M. "Reflections on the Effect of Modern Techniques of Fertility on Family Law." *Medicine and Law* 1 (1982): 15-28.
- Dworkin, A. *Right Wing Women: The Politics of Domesticated Females*. New York: Perigee Books, 1983.
- Easlea, B. *Science and Sexual Oppression: Patriarchy's Confrontation with Women and Nature*. London: Weidenfeld and Nicolson, 1981.
- Eaton, T.A. "Comparative Responses to Surrogate Motherhood." *Nebraska Law Review* 65 (1986): 686-727.
- Eichler, M. *Families in Canada Today: Recent Changes and Their Policy Consequences*. 2d ed. Toronto: Gage Publishing, 1988.
- . "Preconception Contracts for the Production of Children — What Are the Proper Legal Responses." In *Conseil du statut de la femme, Sortir la maternité du laboratoire, Actes du forum international sur les nouvelles technologies de la reproduction organisé par le Conseil du statut de la femme*, Montreal, 1987. Quebec, 1988.
- Eichler, M., and P. Poole. "Incidence of Preconception Contracts for the Production of Children Among Canadians." Report prepared for the Law Reform Commission of Canada. Toronto: Ontario Institute for Studies in Education, 1988.
- Elias, S., and G.J. Annas. "Social Policy Considerations in Noncoital Reproduction." *JAMA* 255 (1986): 62-68.
- Erickson, E.A. "Contracts to Bear a Child." *California Law Review* 66 (1978): 611-22.
- Erlen, J.A., and I.R. Holzman. "Evolving Issues in Surrogate Motherhood." *Health Care for Women International* 11 (1990): 319-29.
- Ettorre, B. "Book Review of *Reproductive Technologies: Gender, Motherhood and Medicine*, ed. M. Stanworth (Cambridge: Polity Press, 1987)." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 215-17.
- Feldman, H. "Changes in Marriage and Parenthood: A Methodological Design." In *Pronatalism: The Myth of Mom & Apple Pie*, ed. E. Peck and J. Senderowitz. New York: Thomas Y. Crowell, 1974.
- Feldman, W.S. "Wombs for Rent: Surrogate Mothers and Semen Donors." *Legal Aspects of Medical Practice* 10 (May 1982): 8.
- Field, M. *Surrogate Motherhood*. Cambridge: Harvard University Press, 1988.
- Firestone, S. *The Dialect of Sex*. New York: Murrow, 1970.
- Fischer, S., and I. Gillman. "Surrogate Motherhood: Attachment, Attitudes and Social Support." *Psychiatry* 54 (February 1991): 13-20.

- Flannery, D.M., et al. "Test Tube Babies: Legal Issues Raised by *In Vitro Fertilization*." *Georgetown Law Journal* 67 (1978-79): 1295-1345.
- Flickinger, R.N. "Surrogate Motherhood: The Attorney's Legal and Ethical Dilemma." *Capital University Law Review* 11 (1982): 593-610.
- Formigli, L., et al. "Surrogate Human Fallopian Tubes for Overcoming Tubal Infertility." *Human Reproduction* 4 (1989): 416-17.
- France, J. "In Vitro Fertilisation: A Brave New World?" *New Zealand Law Journal* (July 1984): 234-36.
- Frankel, T., and F.H. Miller. "The Inapplicability of Market Theory to Adoptions." *Boston University Law Review* 67 (1987): 99-103.
- Franks, D.D. "Psychiatric Evaluation of Women in a Surrogate Mother Program." *American Journal of Psychiatry* 138 (1981): 1378-79.
- Freed, D.J. "As Surrogate Parenting Increases, States Must Resolve Legal Issues." *National Law Journal* 9 (22 December 1986): 28-29.
- Freed, D.J., and H.H. Foster. "Family Law in the Fifty States: An Overview." *Family Law Quarterly* 16 (1983): 289-383.
- Freedman, B. "A Moral Theory of Informed Consent." *Hastings Center Report* 5 (August 1975): 32-39.
- Freeman, M. "Is Surrogacy Exploitative?" In *Legal Issues in Human Reproduction*, ed. S. McLean. Aldershot: Gower, 1989.
- Freeman, M.D.A. "After Warnock — Whither the Law?" *Current Legal Problems* 39 (1986): 33-55.
- Frey, K.L. "New Reproductive Technologies: The Legal Problem and a Solution." *Tennessee Law Review* 49 (1982): 303-42.
- Fridman, G.H.L. *The Law of Contracts*. Toronto: Carswell, 1986.
- Funder, J. "Surrogacy." *Medical Journal of Australia* (3-17 December 1990): 641-43.
- Gabel, P., and J.M. Feinman. "Contract Law as Ideology." In *The Politics of Law: A Progressive Critique*, ed. D. Kairys. New York: Pantheon Books, 1982.
- Garcia, S.A. "The Baby M Case: A Class Struggle over Undefined Rights, Unenforceable Responsibilities, and Inadequate Remedies." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- . "Surrogate Mothering in the Marketplace: Will Sales Law Act as Surrogate for Surrogacy Law?" In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- Garrison, M. "Surrogate Parenting: What Should Legislatures Do?" *Family Law Quarterly* 22 (1988): 149-72.

- Geller, S. "The Child and/or the Embryo. To Whom Does It Belong?" *Human Reproduction* 1 (1986): 561-62.
- Gersz, S.R. "The Contract in Surrogate Motherhood: A Review of the Issues." *Law, Medicine and Health Care* 12 (3)(1984): 107-14.
- Gilliam, R.R. "When a Surrogate Mother Breaks a Promise: The Inappropriateness of the Traditional 'Best Interests of the Child' Standard." *Memphis State University Law Review* 18 (1988): 514-39.
- Gillon, R. "Reproductive Technology: In Britain, the Debate After the Warnock Report." *Hastings Center Report* 17 (Suppl.)(June 1987): 16-18.
- Gladwell, M., and R. Sharpe. "Baby M Winner." *New Republic* (16 February 1987): 15-18.
- Glover, J., et al. *Ethics of New Reproductive Technologies: The Glover Report to the European Commission*. DeKalb: Northern Illinois University Press, 1989.
- Goldstein, J., A. Freud, and A.J. Solnit. *Beyond the Best Interests of the Child*. New York: Free Press, 1973.
- Gordon, M. "'Baby M': New Questions About Biology and Destiny." Ms. 15 (June 1987): 25-26, 28.
- Gorovitz, S. "Engineering Human Reproduction: A Challenge to Public Policy." *Journal of Medicine and Philosophy* 10 (1985): 267-74.
- Gostin, L. "A Civil Liberties Analysis of Surrogacy Arrangements." *Law, Medicine and Health Care* 16 (1-2)(1988): 7-17.
- Graham, M.L. "Surrogate Gestation and the Protection of Choice." *Santa Clara Law Review* 22 (1982): 291-323.
- Grant, I. "Forced Obstetrical Intervention: A Charter Analysis." *University of Toronto Law Journal* 39 (1989): 217-57.
- Graversen, J. "Denmark: Legislation on Surrogate Maternity and Other Developments." *Journal of Family Law* 26 (1987-88): 59-67.
- Greenberg, L.J., and H.L. Hirsh. "Surrogate Motherhood and Artificial Insemination: Contractual Implications." *Medical Trial Technique Quarterly* 29 (1983): 149-66.
- Hall, M. "Rights and the Problem of Surrogate Parenting." *Philosophical Quarterly* 35 (October 1985): 414-24.
- Hancock, L. "Review of *The Baby Machine: Commercialisation of Motherhood*, ed. J.A. Scutt (Melbourne: McCulloch Publishing, 1988)." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 2 (1989): 186-89.
- Handel, W.W. "Surrogate Parenting, In Vitro Insemination and Embryo Transplantation." *Whittier Law Review* 6 (1984): 783-88.

- Hansbrough, N. "Surrogate Motherhood and Tort Liability: Will the New Reproductive Technologies Give Birth to a New Breed of Prenatal Tort?" *Cleveland State Law Review* 34 (1985-86): 311-48.
- Harkness, C. "Surrogate Mothers." In *The Infertility Book: A Comprehensive Medical and Emotional Guide*. San Francisco: Volcano Press, 1987.
- Harris, L.E. "Artificial Insemination and Surrogate Motherhood — A Nursery of Full Unresolved Questions." *Williamette Law Review* 17 (1981): 913-52.
- Heitlinger, A. "Current Medical, Legal and Demographic Perspectives on Artificial Reproduction in Czechoslovakia." *American Journal of Public Health* 79 (1989): 57-61.
- Hirsh, B.D. "Parenthood by Proxy." *JAMA* 249 (1983): 2251-52.
- Hirsh, H.L. "Surrogate Motherhood: The Legal Climate for the Physician." *Medicine and Law* 5 (1986): 151-67.
- Holder, A.R. *Legal Issues in Pediatrics and Adolescent Medicine*. New York: John Wiley, 1977.
- . "Surrogate Motherhood and the Best Interests of Children." *Law, Medicine and Health Care* 16 (1-2)(1988): 51-56.
 - . "Surrogate Motherhood: Babies for Fun and Profit." *Law, Medicine and Health Care* 12 (3)(1984): 115-17.
- Hollinger, J.H. "From Coitus to Commerce: Legal and Social Consequences of Noncoital Reproduction." *University of Michigan Journal of Law Reform* 18 (1985): 865-932.
- Holmes, H.B. "Surrogacy with IVF Carries Biological Risks." *Hastings Center Report* 16 (August 1986): 49.
- Holmes, H.B., B.B. Hoskins, and M. Gross, eds. *The Custom-Made Child? Women-Centered Perspectives*. Clifton: Humana Press, 1981.
- Hull, R.T., ed. *Ethical Issues in the New Reproductive Technologies*. Belmont: Wadsworth, 1990.
- Iglesias, T. "In Vitro Fertilisation: The Major Issues." *Journal of Medical Ethics* 18 (1984): 32-37.
- Ince, S. "Inside the Surrogate Industry." In *Test-Tube Women: What Future for Motherhood?* ed. R. Arditti, R.D. Klein, and S. Minden. London: Pandora Press, 1984.
- Jabro, J. "Surrogate Motherhood: The Outer Limits of Protected Conduct." *Detroit College of Law Review* 4 (1981): 1131-46.
- Jacob, J. "Biomedical Law: Lost Horizons Regained." *Modern Law Review* 46 (1983): 21-38.

- Johnson, S.H. "The Baby 'M' Decision: Specific Performance of a Contract for Specially Manufactured Goods." *Southern Illinois University Law Journal* 11 (1987): 1339-48.
- Jones, K.B. "Surrogate Motherhood and Criminal Law." *Pennsylvania Medicine* 87 (January 1984): 22.
- Jordan, B., and S.L. Irwin. "The Ultimate Failure: Court-Ordered Cesarean Section." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- Kane, E. *Birth Mother: America's First Legal Surrogate Mother Tells the Story of Her Change of Heart*. San Diego: Harcourt Brace Jovanovich, 1988.
- . "Surrogate Parenting: A Division of Families, Not a Creation." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 2 (1989): 105-109.
- Kapp, M.B. "Book Review of *The Surrogate Mother*." *Law, Medicine and Health Care* 10 (1982): 228-29.
- Kasirer, N. "The Surrogate Motherhood Agreement: A Proposed Standard Form Contract for Quebec." *Revue de Droit de l'Université de Sherbrooke* 16 (1985): 351-87.
- Kass, L.R. "Making Babies — The New Biology and the 'Old' Morality." *Public Interest* 26 (Winter 1972): 18-56.
- Katz, A. "Surrogate Motherhood and the Baby-Selling Laws." *Columbia Journal of Law and Social Problems* 20 (1986): 1-53.
- Katz, B.F. "Legal Implications and Regulation of *In Vitro* Fertilization." In *Genetics and the Law II*, ed. A. Milunsky and G.J. Annas. New York: Plenum Press, 1980.
- Keane, N.P. "Legal Problems of Surrogate Motherhood." *Southern Illinois University Law Journal* (1980): 147-69.
- Keane, N.P., and D.L. Breo. *The Surrogate Mother*. New York: Everest House, 1981.
- Keyserlingk, E.W. "Legal Complexities in New Reproductive Techniques." *Annals of the Royal College of Physicians and Surgeons of Canada* 17 (1984): 419-28.
- Kirby, M.D. "From Hagar to Baby Cotton — Surrogacy, '85." *Australian and New Zealand Journal of Obstetrics and Gynaecology* 25 (1985): 151-58.
- Knoppers, B.M. "Modern Birth Technology and Human Rights." *American Journal of Comparative Law* 33 (1985): 1-31.
- . "Reproductive Technology and International Mechanisms of Protection of the Human Person." *McGill Law Journal* 32 (1987): 336-58.

- . "Women and the Reproductive Technologies." In *Family Law in Canada: New Directions*, ed. E. Sloss. Ottawa: Canadian Advisory Council on the Status of Women, 1985.
- Knoppers, B.M., and E. Sloss. "Recent Developments: Legislative Reforms in Reproductive Technology." *Ottawa Law Review* 18 (1986): 663-719.
- Krause, H.D. "Artificial Conception: Legislative Approaches." *Family Law Quarterly* 19 (1985): 185-206.
- Krimmel, H.T. "The Case Against Surrogate Parenting." *Hastings Center Report* 13 (October 1983): 35-39.
- Laborie, F. "New Reproductive Technologies: News from France and Elsewhere." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 77-85.
- Lacey, L.J. "The Law of Artificial Insemination and Surrogate Parenthood in Oklahoma: Roadblocks to the Right to Procreate." *Tulsa Law Journal* 22 (1987): 281-324.
- Landes, E.M., and R.A. Posner. "The Economics of the Baby Shortage." *Journal of Legal Studies* 7 (1978): 323-48.
- La Puma, J., D.L. Schiedermayer, and J. Grover. "Surrogacy and Shakespeare: The Merchant's Contract Revisited." *American Journal of Obstetrics and Gynecology* 160 (1989): 59-62.
- Lasker, J.N., and S. Borg. "Secrecy and the New Reproductive Technologies." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- Laukaran, V.H., and B.J. van den Berg. "The Relationship of Maternal Attitude to Pregnancy Outcomes and Obstetric Complications." *American Journal of Obstetrics and Gynecology* 136 (1980): 374-79.
- Lauritzen, P. "What Price Parenthood?" *Hastings Center Report* 20 (March-April 1990): 38-46.
- Lee, S. "Re-Reading Warnock." In *Rights and Wrongs in Medicine*, ed. P. Byrne. London: King Edward's Hospital Fund for London, 1986.
- Levine, C. "In Britain and Australia, New In Vitro Guidelines." *Hastings Center Report* 13 (February 1983): 2.
- Lockwood, M., ed. *Moral Dilemmas in Modern Medicine*. New York: Oxford University Press, 1986.
- Lorio, K.V. "In Vitro Fertilization and Embryo Transfer: Fertile Areas for Litigation." *Southwestern Law Journal* 35 (1982): 973-1011.
- Lupton, M.L. "The Right to Be Born: Surrogacy and the Legal Control of Human Fertility." *Medicine and Law* 7 (1989): 483-503.

- McAuliffe, S., and K. McAuliffe. *Life for Sale*. New York: Coward, McCann and Geoghegan, 1981.
- McCormack, T. "Public Policies and Reproductive Technology: A Feminist Critique." *Canadian Public Policy* 14 (1988): 361-75.
- Macklin, R. "Is There Anything Wrong with Surrogate Motherhood?: An Ethical Analysis." *Law, Medicine and Health Care* 16 (1-2)(1988): 57-64.
- McLay, J. "The Legislature and Bioethical Problems." *New Zealand Law Journal* (1984): 231-33.
- Mady, T.M. "Surrogate Mothers: The Legal Issues." *American Journal of Law and Medicine* 7 (1981): 323-52.
- Mahoney, J. "An Essay on Surrogacy and Feminist Thought." *Law, Medicine and Health Care* 16 (1-2)(1988): 81-88.
- Mallory, T.E., and K.E. Rich. "Human Reproductive Technologies: An Appeal for Brave New Legislation in a Brave New World." *Washburn Law Journal* 25 (1986): 458-504.
- Mandler, J.J. "Developing a Concept of the Modern Family: A Proposed Uniform Surrogate Parenthood Act." *Georgetown Law Journal* 73 (1985): 1283-1329.
- Marcus, I., et al. "The James McCormick Mitchell Lecture — Looking Toward the Future: Feminism and Reproductive Technologies." *Buffalo Law Review* 37 (1988-89): 203-55.
- Martin, D.K. "Surrogate Motherhood: Contractual Issues and Remedies Under Legislative Proposals." *Washburn Law Journal* 23 (1984): 601-37.
- Martin, G. "Held Hostage: A New Twist." *Journal of Perinatology* 10 (1990): 345-46.
- Martin, S.L. *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms, and the Canada Health Act*. Background Paper. Ottawa: Canadian Advisory Council on the Status of Women, 1989.
- Mason, K., and J. Crawford. "The Cross-Vesting Scheme." *Australian Law Journal* 62 (1988): 328-46.
- Mason, S. "Abnormal Conception." *Australian Law Journal* 56 (1982): 347-57.
- Mellown, M.R. "An Incomplete Picture: The Debate About Surrogate Motherhood." *Harvard Women's Law Journal* 8 (1985): 231-46.
- Mies, M. "Why Do We Need All This? A Call Against Genetic Engineering and Reproductive Technology." *Women's Studies International Forum* 8 (1985): 553-60.

- Miller, S.L. "Surrogate Parenthood and Adoption Statutes: Can a Square Peg Fit into a Round Hole?" *Family Law Quarterly* 22 (1988): 199-212.
- Mitchell, G.D. "In Vitro Fertilisation: The Major Issues — A Comment." *Journal of Medical Ethics* 9 (1983): 197-99.
- Moghissi, K.S. "The Technology of AID and Surrogacy." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- Montgomery, J. "Constructing a Family — After a Surrogate Birth." *Modern Law Review* 49 (1986): 635-40.
- Morgan, D. "Who To Be or Not To Be: The Surrogacy Story." *Modern Law Review* 49 (1986): 358-68.
- Morgan, J.L. "The Created Individual: Are Basic Notions of Humanity Threatened?" In *Test-Tube Babies*, ed. W.A.W. Walters and P. Singer. Melbourne: Oxford University Press, 1982.
- Mullooly, J.P. "Surrogate Motherhood." *Wisconsin Medical Journal* 88 (June 1989): 8.
- Murray, T.H. "On the Human Body as Property: The Meaning of Embodiment, Markets, and the Meaning of Strangers." *University of Michigan Journal of Law Reform* 20 (1987): 1055-88.
- New South Wales. Law Reform Commission. *Artificial Conception: Surrogate Motherhood: Australian Public Opinion*. Research Report. Sydney: NSW Government Printer, 1987.
- . *Artificial Conception: Surrogate Motherhood*. Report LRC 60. Sydney: NSW Government Printer, 1988.
- O'Brien, M. *The Politics of Reproduction*. London: Routledge and Kegan Paul, 1981.
- . "State Power and Reproductive Freedom." *Canadian Woman Studies/Les cahiers de la femme* 6 (3)(1985): 62-66.
- O'Brien, S. "Commercial Conceptions: A Breeding Ground for Surrogacy." *North Carolina Law Review* 65 (November 1986): 127-53.
- O'Brien, S. "The Itinerant Embryo and the Neo-Nativity Scene: Bifurcating Biological Maternity." *Utah Law Review* (1987): 1-33.
- O'Donovan, O. *Begotten or Made?* Oxford: Oxford University Press, 1984.
- Ontario Law Reform Commission. *Report on Human Artificial Reproduction and Related Matters*. 2 vols. Toronto: Ministry of Attorney General, 1985.
- Orland, B. "Having Children — A Matter of High Technology (Report of the 13th German Congress for Perinatal Medicine in Berlin)." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 209-12.

- Overall, C. *Ethics and Human Reproduction: A Feminist Analysis*. Boston: Allen and Unwin, 1987.
- . "Pluck a Fetus from Its Womb": A Critique of Current Attitudes Toward the Embryo/Fetus." *University of Western Ontario Law Review* 24 (1)(1986): 1-14.
- . "Surrogate Motherhood." In *Science, Morality and Feminist Theory*, ed. M. Hanen and K. Nielsen. Calgary: University of Calgary Press, 1987.
- Overduin, D.C., and J.I. Fleming. *Life in a Test-Tube: Medical and Ethical Issues Facing Society Today*. Adelaide: Lutheran Publishing House, 1982.
- Palm, M.T., and H.L. Hirsh. "Legal Implications of Artificial Conception: Making Babies Makes Law." *Medical Trial Technique Quarterly* 28 (1982): 404-23.
- Parker, P.J. "Motivation of Surrogate Mothers: Initial Findings." *American Journal of Psychiatry* 140 (1983): 117-18.
- . "Surrogate Motherhood, Psychiatric Screening and Informed Consent, Baby Selling, and Public Policy." *Bulletin of the American Academy of Psychiatry and the Law* 12 (1)(1984): 21-39.
- . "Surrogate Motherhood: The Interaction of Litigation, Legislation, and Psychiatry." *International Journal of Law and Psychiatry* 5 (1982): 341-54.
- Patterson, S.M. "Parenthood by Proxy: Legal Implications of Surrogate Birth." *Iowa Law Review* 67 (1982): 385-99.
- Payne, V.L. "The Regulation of Surrogate Motherhood." *Family Law* 17 (1987): 178-80.
- P.C. "Surrogacy Agencies Shut." *Nature* 329 (1987): 753.
- Peck, E., and J. Senderowitz, eds. *Pronatalism: The Myth of Mom & Apple Pie*. New York: Thomas Y. Crowell, 1974.
- Petchesky, R.P. "Reproduction Freedom: 'Beyond a Woman's Right to Choose.'" In *Women: Sex and Sexuality*, ed. C.R. Stimpson and E. Spector Person. Chicago: University of Chicago Press, 1981.
- Phillips, J.W., and S.D. Phillips. "In Defense of Surrogate Parenting: A Critical Analysis of the Recent Kentucky Experience." *Kentucky Law Journal* 69 (1980-81): 877-931.
- Pohlman, E. "Motivations in Wanting Conceptions." In *Pronatalism: The Myth of Mom & Apple Pie*, ed. E. Peck and J. Senderowitz. New York: Thomas Y. Crowell, 1974.
- Pollitt, K. "Contracts and Apple Pie: The Strange Case of Baby M." *Nation* 244 (1987): 667, 682-88.

- Posner, R.A. "The Regulation of the Market in Adoptions." *Boston University Law Review* 67 (1987): 59-72.
- Priest, J.A. "Assisted Reproduction — Developments in England." *International and Comparative Law Quarterly* 37 (1988): 535-50.
- . "The Report of the Warnock Committee on Human Fertilisation and Embryology." *Modern Law Review* 48 (1985): 73-85.
- Purdy, L.M. "Surrogate Mothering: Exploitation or Empowerment." *Bioethics* 3 (1989): 18-34.
- Québec. Conseil du statut de la femme. "General Opinion of the Conseil du statut de la femme in Regard to New Reproductive Technologies." Quebec, 1989.
- . *Sortir la maternité du laboratoire*. Actes du forum international sur les nouvelles technologies de la reproduction organisé par le Conseil du statut de la femme, Montreal, 1987. Quebec, 1988.
- Rachels, J. "A Report from America: Baby M." *Bioethics* 1 (1987): 357-65.
- Radin, M.J. "Market-Inalienability." *Harvard Law Review* 100 (1987): 1928-37.
- Rassaby, A.A. "Surrogate Motherhood: The Position and Problems of Substitutes." In *Test-Tube Babies*, ed. W. Walters and P. Singer. Melbourne: Oxford University Press, 1982.
- Raymond, J.G. "In the Matter of Baby M: Rejudged." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 175-81.
- . "The International Traffic in Women: Women Used in Systems of Surrogacy and Reproduction." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 2 (1989): 51-57.
- . "Making International Connections: Surrogacy, the Traffic in Women and De-Mythologizing Motherhood." In Conseil du statut de la femme, *Sortir la maternité du laboratoire*, Actes du forum international sur les nouvelles technologies de la reproduction organisé par le Conseil du statut de la femme, Montreal, 1987. Quebec, 1988.
- . "Of Eggs, Embryos and Altruism." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 281-85.
- . "Reproductive Gifts and Gift Giving: The Altruistic Woman." *Hastings Center Report* 20 (November-December 1990): 7-11.
- . "Reproductive Technologies, Radical Feminism, and Socialist Liberalism." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 2 (1989): 133-42.

- . "The Spermatic Market: Surrogate Stock and Liquid Assets." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 65-75.
- Reame, N.E., and P.J. Parker. "Surrogate Pregnancy: Clinical Features of Forty-four Cases." *American Journal of Obstetrics and Gynecology* 162 (1990): 1220-25.
- Reidinger, P. "Lawyers Reject Surrogate Mothers' Claims: Lawpoll." *ABA Journal* (1 June 1987): 55.
- Reilly, P. "In Vitro Fertilization — A Legal Perspective." In *Genetics and the Law*, ed. A. Milunsky and G.J. Annas. New York: Plenum Press, 1976.
- Reproductive and Genetic Engineering, *Journal of International Feminist Analysis*. Volume 1, 1988 —.
- "Reproductive Technology and the Procreation Rights of the Unmarried." *Harvard Law Review* 98 (1985): 669-85.
- Richardson, H., ed. *On the Problem of Surrogate Parenthood: Analyzing the Baby M Case*. Lewiston: Edwin Mellen Press, 1987.
- Riegler, J., and A. Weikert. "Product Egg: Egg Selling in an Austrian IVF Clinic." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 221-23.
- Roach, S.L. "New Reproductive Technologies and Legal Reform." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 2 (1989): 11-27.
- Robertson, J.A. "Embryo Research." *University of Western Ontario Law Review* 24 (1986): 15-37.
- . "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction." *Southern California Law Review* 59 (1986): 939-1041.
- . "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth." *Virginia Law Review* 69 (1983): 405-64.
- . "The Right to Procreate and In Utero Fetal Therapy." *Journal of Legal Medicine* 3 (1982): 333-66.
- . "Surrogate Mothers: Not So Novel After All." *Hastings Center Report* 13 (October 1983): 28-34.
- Roiphe, A. "What's a Mother to Do." (Book reviews of *A Mother's Story*, by M.B. Whitehead, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*, by B.K. Rothman, and *Between Strangers*, by L. Andrews.) Ms. 17 (May 1989): 26, 28.
- Rosenblatt, R. "The Baby in the Factory." *Time* (14 February 1983): 72.
- Rosner, F. "In Vitro Fertilization and Surrogate Motherhood: The Jewish View." *Journal of Religion and Health* 22 (Summer 1983): 139-60.

- Rothenberg, K.H. "Baby M, the Surrogacy Contract, and the Health Care Professional: Unanswered Questions." *Law, Medicine and Health Care* 16 (1-2)(1988): 113-20.
- . "Gestational Surrogacy and the Health Care Provider: Put Part of the 'IVF Genie' Back into the Bottle." *Law, Medicine and Health Care* 18 (4)(1990): 345-52.
- Rothman, B.K. "The Products of Conception: The Social Context of Reproductive Choices." *Journal of Medical Ethics* 11 (1985): 188-92.
- . "Reproductive Technology and the Commodification of Life." In *Embryos, Ethics, and Women's Rights: Exploring the New Reproductive Technologies*, ed. E.H. Baruch, A.F. D'Adamo, Jr., and J. Seager. New York: Harrington Park Press, 1988.
- . "When a Pregnant Woman Endangers Her Fetus: Commentary." *Hastings Center Report* 16 (February 1986): 25.
- Rousseau, F., and P.R. Desrosier. *Nouvelles technologies de la reproduction: Questions soulevées dans la littérature générale*. Quebec: Conseil du statut de la femme, 1985.
- Rowland, R. "A Child at ANY Price? An Overview of Issues in the Use of the New Reproductive Technologies, and the Threat to Women." *Women's Studies International Forum* 8 (1985): 539-46.
- . "Maternity in the Laboratory: An International Forum on the New Reproductive Technologies." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 213-14.
- . "Technology and Motherhood: Reproductive Choice Reconsidered." *Signs: Journal of Women in Culture and Society* 12 (1987): 512-28.
- "Rumpelstiltskin Revisited: The Inalienable Rights of Surrogate Mothers." *Harvard Law Review* 99 (1986): 1936-55.
- Rushevsky, C.A. "Legal Recognition of Surrogate Gestation." *Women's Rights Law Reporter* 7 (1982): 107-42.
- Russell, I.S. "Within the Best Interests of the Child: The Factor of Parental Status in Custody Disputes Arising from Surrogacy Contracts." *Journal of Family Law* 27 (1988-89): 587-671.
- Rust, M. "Whose Baby Is It? Surrogate Motherhood After Baby M." *ABA Journal* 73 (1 June 1987): 52-56.
- Ryan, D. "Surrogate Mothers." *Legal Service Bulletin* 7 (1982): 33-34.
- Saltz, I. "Better Off Never Born?" *ABA Journal* 72 (1 April 1986): 46-49.
- Samuels, A. "Warnock Committee: Human Fertilisation and Embryology." *Medico-Legal Journal* 51 (1983): 174-78.

- Sandberg, E.C. "Only an Attitude Away: The Potential of Reproductive Surrogacy." *American Journal of Obstetrics and Gynecology* 160 (1989): 1441-46.
- Sappideen, C. "The Surrogate Mother — A Growing Problem." *University of New South Wales Law Journal* 6 (1983): 79-102.
- Schroeder, L.O. "New Life: Person or Property?" *American Journal of Psychiatry* 131 (1974): 541-44.
- Schuler, J. "Baby M and the Politics of Gender." *Telos: A Quarterly of Critical Thought* 74 (1987-88): 126-33.
- Schwartz, L.L. "Surrogate Motherhood I: Responses to Infertility." *American Journal of Family Therapy* 15 (1987): 158-62.
- Scott, R. "Bioethics: Experimental Medicine." *New Zealand Law Journal* (1984): 228-30.
- Scutt, J.A. "Book Review of *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies*, by L. Andrews (New York: Harper and Row, 1989) and *My Sister's Child: Maggie and Linda Kirkman — Their Own Story*, by M. Kirkman and L. Kirkman (Ringwood: Penguin Books (Australia), 1988)." *Issues in Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 3 (1990): 73-76.
- Serhal, P. "Oocyte Donation and Surrogacy." *British Medical Bulletin* 46 (1990): 796-812.
- Shaman, J.M. "Legal Aspects of Artificial Insemination." *Journal of Family Law* 18 (1979-80): 331-51.
- Shannon, T.A. *Surrogate Motherhood: The Ethics of Using Human Beings*. New York: Crossroad, 1988.
- Shapiro, E.D. "New Innovations in Conception and Their Effects upon Our Law and Morality." *New York Law School Law Review* 31 (1986): 37-59.
- Shapiro, E.D., and L. Schultz. "Single-Sex Families: The Impact of Birth Innovations upon Traditional Family Notions." *Journal of Family Law* 24 (1985-86): 271-81.
- Sheean, L.A., et al. "In Vitro Fertilization (IVF)-Surrogacy: Application of IVF to Women Without Functional Uteri." *Journal of In Vitro Fertilization and Embryo Transfer* 6 (June 1989): 134-37.
- Sheehy, E. *Personal Autonomy and the Criminal Law: Emerging Issues for Women*. Ottawa: Canadian Advisory Council on the Status of Women, 1987.
- Sherwyn, B.A. "Attorney Duties in the Area of New Reproductive Technologies." *Whittier Law Review* 6 (1984): 799-810.

- Silber, T., ed. *Ethical and Legal Issues in Perinatology*. Philadelphia: W.B. Saunders, 1987.
- Silva-Ruiz, P.F. "Artificial Reproduction Techniques, Fertility Regulation: The Challenge of Contemporary Family Law." *American Journal of Comparative Law* 34 (Suppl.)(1986): 125-40.
- Singer, P. "Making Laws on Making Babies." *Hastings Center Report* 15 (August 1985): 5-6.
- Singer, P., and D. Wells. *Making Babies: The New Science and Ethics of Conception*. New York: Charles Scribner's, 1985.
- . *The Reproduction Revolution: New Ways of Making Babies*. Oxford: Oxford University Press, 1984.
- Slovenko, R. "Obstetric Science and the Developing Role of the Psychiatrist in Surrogate Motherhood." *Journal of Psychiatry and Law* 13 (Fall/Winter 1985): 487-518.
- Sly, K.M. "Baby-Sitting Consideration: Surrogate Mother's Right to 'Rent Her Womb' for a Fee." *Gonzaga Law Review* 18 (1982-83): 539-65.
- Smith, D.A. "Editorial: Surrogacy Questions Involve Ethics." *Pennsylvania Medicine* 9 (March 1987): 8.
- Smith, D.H. "Wombs for Rent, Selves for Sale?" *Journal of Contemporary Health Law and Policy* 4 (Spring 1988): 23-36.
- Smith II, G.P. "The Case of Baby M: Love's Labor Lost." *Law, Medicine and Health Care* 16 (1-2)(1988): 121-25.
- . "The Perils and Peregrinations of Surrogate Mothers." *Medicine and Law* 1 (1982): 325-33.
- Smith II, G.P., and R. Iraola. "Sexuality, Privacy and the New Biology." *Marquette Law Review* 67 (1984): 263-91.
- Smith, P.K. "Ethics and In-Vitro Fertilisation." *British Medical Journal* (1 May 1982): 1287.
- Snitow, A. "The Paradox of Birth Technology." *Ms.* 15 (December 1986): 42, 44, 46, 76-77.
- Snowden, R., G.D. Mitchell, and E.M. Snowden. *Artificial Reproduction: A Social Investigation*. London: George Allen and Unwin, 1983.
- Sokoloff, B.Z. "Alternative Methods of Reproduction: Effects on the Child." *Clinical Pediatrics* 26 (1987): 11-17.
- Spallone, P. "The First International Conference on Philosophical Ethics in Reproductive Medicine and Challenging Issues in Bioethics, International Seminar of the Fondazione." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 309-12.

- . "Reproductive Technology and the State: The Warnock Report and Its Clones." In *Made to Order: The Myth of Reproductive and Genetic Progress*, ed. P. Spallone and D.L. Steinberg. Oxford: Pergamon Press, 1987.
- . "The Warnock Report: The Politics of Reproductive Technology." *Women's Studies International Forum* 9 (1986): 543-50.
- Spallone, P., and D.L. Steinberg, eds. *Made to Order: The Myth of Reproductive and Genetic Progress*. Oxford: Pergamon Press, 1987.
- Steadman, J.H., and G.T. McCloskey. "The Prospect of Surrogate Mothering: Clinical Concerns." *Canadian Journal of Psychiatry* 32 (October 1987): 545-50.
- Steeves, S.M. "Artificial Human Reproduction: Legal Problems Presented by the Test Tube Baby." *Emory Law Journal* 28 (1979): 1045-79.
- Steinbock, B. "Surrogate Motherhood as Prenatal Adoption." *Law, Medicine and Health Care* 16 (1-2)(1988): 44-50.
- Stetson, S. "Whose Children Are They?: The Moral and Legal Dilemmas of Surrogate Parenting." *Empire State Report* 13 (May 1987): 56-58ff.
- Stevens, K. *Surrogate Mother: One Woman's Story*. London: Century, 1985.
- Stolcke, V. "New Reproductive Technologies: The Old Quest for Fatherhood." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 5-19.
- Stumpf, A.E. "Redefining Mother: A Legal Matrix for New Reproductive Technologies." *Yale Law Journal* 96 (1976): 187-208.
- Suender, J.M. "Surrogate Motherhood Agreements and the Law in Pennsylvania." *Dickinson Law Review* 91 (1987): 1085-1111.
- Suh, M.M. "Surrogate Motherhood: An Argument for Denial of Specific Performance." *Columbia Journal of Law and Social Problems* 22 (1989): 357-95.
- "Surrogate Motherhood and the Appeal in the Baby M Case." *Australian Law Journal* 62 (1988): 324-27.
- "Surrogate Mothers." *British Medical Journal* (26 January 1985): 308.
- "Surrogate Parenting and Right to Life Debated." *Canadian Medical Association Journal* 130 (1984): 65-67.
- Tait, J.J. "Ethical Issues in Reproductive Technology: A Feminist Perspective." *Canadian Woman Studies/Les cahiers de la femme* 6 (2)(1985): 40-45.
- Taub, N. "Amicus Brief: In the Matter of Baby M." *Women's Rights Law Reporter* 10 (Spring 1987): 7-24.
- . "Surrogacy: A Preferred Treatment for Infertility?" *Law, Medicine and Health Care* 16 (1-2)(1988): 89-95.

- Taub, S. "Surrogate Motherhood and the Law." *Connecticut Medicine* 49 (1985): 671-74.
- Thom, M. "Dilemmas of the New Birth Technologies." *Ms.* 16 (May 1988): 70-76.
- Thomas, A.K. "Human Embryo Experimentation and Surrogacy." *Medical Journal of Australia* (October 1990): 369-71.
- Tiller, S.L. "Litigation, Legislation, and Limelight: Obstacles to Commercial Surrogate Mother Arrangements." *Iowa Law Review* 72 (1987): 415-44.
- Tomlinson, T. "Surrogacy Revisited." *Hastings Center Report* 19 (May-June 1989): 44-45.
- Townsend, M.D. "Surrogate Mother Agreements: Contemporary Legal Aspects of a Biblical Notion." *University of Richmond Law Review* 16 (1982): 467-83.
- Trebilcot, J., ed. *Mothering: Essays in Feminist Theory*. Totowa: Rowman and Allanheld, 1984.
- Turk, A.M. "If Baby M Were a Californian ... Our Courts Have Not Ruled on Surrogate Contracts, but the Issue Is Gestating." *California Lawyer* 7 (August 1987): 69.
- United Kingdom. Department of Health and Social Security. *Report of the Committee of Inquiry into Human Fertilisation and Embryology*. Cmnd 9314. London: HMSO, 1984.
- United States. Congress. Office of Technology Assessment. *Infertility: Medical and Social Choices*. Washington, DC: U.S. Government Printing Office, 1988.
- . *Infertility: Medical and Social Choices — Summary*. Washington, DC: U.S. Government Printing Office, 1988.
- Utian, W., et al. "Preliminary Experience with In Vitro Fertilization-Surrogate Gestational Pregnancy." *Fertility and Sterility* 52 (1989): 633-38.
- Vandelac, L. "Mothergate: Surrogate Mothers, Linguistics, and Androcentric Engineering." In *Gender and Society: Creating a Canadian Women's Sociology*, ed. A.T. McLaren. Toronto: Copp Clark Pitman, 1988.
- . "Sexes et technologies de procréation: 'mères porteuses' ou la maternité deportée par la langue..." *Sociologie et sociétés* 19 (April 1987): 97-115.
- Van Hoften, E.L. "Surrogate Motherhood in California: Legislative Proposals." *San Diego Law Review* 18 (1981): 341-85.
- Veile, B. "Surrogate Motherhood: The Need for Social Acceptance." *Ohio Northern University Law Review* 13 (1986): 517-36.

- Vetri, D. "Reproductive Technologies and United States Law." *International and Comparative Law Quarterly* 37 (1988): 505-34.
- Waddams, S.M. *The Law of Contracts*. 2d ed. Toronto: Canada Law Book, 1984.
- Wadlington, W. "Artificial Conception: The Challenge for Family Law." *Virginia Law Review* 69 (1983): 465-514.
- Waller, L. "Borne for Another." *Monash University Law Review* 10 (1984): 113-30.
- Walters, L. "Ethical Aspects of Surrogate Embryo Transfer." *JAMA* 250 (October 1983): 2183-84.
- . "Ethics and New Reproductive Technologies: An International Review of Committee Statements." *Hastings Center Report* 17 (Suppl.)(June 1987): 3-9.
- . "Human In Vitro Fertilization: A Review of the Ethical Literature." *Hastings Center Report* 9 (August 1979): 23-43.
- Walters, W.A.W. "Ethical Aspects of Surrogacy." *Australian and New Zealand Journal of Obstetrics and Gynecology* 29 (1989): 322-25.
- Warnock, M. "The Good of the Child." *Bioethics* 1 (1987): 141-55.
- . *A Question of Life: The Warnock Report on Human Fertilization and Embryology*. New York: Basil Blackwell, 1985.
- Wettstein, R.M. "Surrogate Parenting Contracts." *American Journal of Obstetrics and Gynecology* 163 (1990): 679-80.
- Whiteford, L.M. "Commercial Surrogacy: Social Issues Behind the Controversy." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M.L. Poland. Boulder: Westview Press, 1989.
- Whiteford, L.M., and M.L. Poland. *New Approaches to Human Reproduction: Social and Ethical Dimensions*. Boulder: Westview Press, 1989.
- Whitehead, M.B. *A Mother's Story*. New York: St. Martin's, 1989.
- Wikler, N.J. "Society's Response to the New Reproductive Technologies: The Feminist Perspectives." *Southern California Law Review* 59 (1986): 1043-57.
- Williams, E. "The Midwife and the Surrogate Childbearing Family." *Nursing RSA* 4 (September 1989): 26-27.
- Williams, J.F. "Differential Treatment of Men and Women by Artificial Reproduction Statutes." *Tulsa Law Journal* 21 (1986): 463-84.
- Williams, L.S. *But What Will They Mean for Women? Feminist Concerns About the New Reproductive Technologies*. Ottawa: Canadian Research Institute for the Advancement of Women, 1986.

- Wilson, J., and M. Tomlinson. *Wilson: Children and the Law*. 2d ed. Toronto: Butterworths, 1986.
- Winkler, U. "New U.S. Know-How in Frankfurt — A 'Surrogate Mother Agency.'" *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (1988): 205-207.
- Winslade, W.J. "Surrogate Mothers: Private Right or Public Wrong?" *Journal of Medical Ethics* 7 (1981): 153-54.
- Wolfram, S. "Surrogacy in the United Kingdom." In *New Approaches to Human Reproduction: Social and Ethical Dimensions*, ed. L.M. Whiteford and M. Poland. Boulder: Westview Press, 1989.
- Wright, M. "Surrogacy and Adoption: Problems and Possibilities." *Family Law* 16 (April 1986): 109-13.
- Young, D.M. "Surrogate Motherhood Legislation: A Sensible Starting Point." *Indiana Law Review* 20 (1987): 879-907.
- Zipper, J., and S. Sevenhuijsen. "Surrogacy: Feminist Notions of Motherhood Reconsidered." In *Reproductive Technologies: Gender, Motherhood and Medicine*, ed. M. Stanworth. Minneapolis: University of Minnesota Press, 1987.

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Mandate

(approved by Her Excellency the Governor General
on the 25th day of October, 1989)

The Committee of the Privy Council, on the recommendation of the Prime Minister, advise that a Commission do issue under Part I of the Inquiries Act and under the Great Seal of Canada appointing The Royal Commission on New Reproductive Technologies to inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied, and examining in particular,

- (a) implications of new reproductive technologies for women's reproductive health and well-being;
- (b) the causes, treatment and prevention of male and female infertility;
- (c) reversals of sterilization procedures, artificial insemination, *in vitro* fertilization, embryo transfers, prenatal screening and diagnostic techniques, genetic manipulation and therapeutic interventions to correct genetic anomalies, sex selection techniques, embryo experimentation and fetal tissue transplants;
- (d) social and legal arrangements, such as surrogate childbearing, judicial interventions during gestation and birth, and "ownership" of ova, sperm, embryos and fetal tissue;
- (e) the status and rights of people using or contributing to reproductive services, such as access to procedures, "rights" to parenthood, informed consent, status of gamete donors and confidentiality, and the impact of these services on all concerned parties, particularly the children; and
- (f) the economic ramifications of these technologies, such as the commercial marketing of ova, sperm and embryos, the application of patent law, and the funding of research and procedures including infertility treatment.

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